

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G249 9/25/59 iwk

10323

10377

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 114 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ilona Benczsko ADAMS		4. DATE OF DEATH Month Day Year September 18 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-09
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Journalist		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter BENCZSKO		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT (H) Harold W. Adams, same as #2 above	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Glioblastoma multiforme DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 27 , 19 59 , to Sept. 18 , 19 59 , that I last saw the deceased alive on Sept. 18 , 19 59 , and that death occurred at 1035PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Druckemiller		DATE SIGNED 9-19-59	
PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation-Shipment		22b. DATE THEREOF 8/21/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Funeral Home, Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Evans	

10317

Montgomery

Virginia

Alexandria

Rebecca (Mrs.)

111 days

Alexandria

U. S. Naval Hospital

1119 Evergreen Drive

Ilona

Benjamin

Adam

September 18 39

Rebecca (Mrs.)

11-13-39

49

Rebecca (Mrs.)

Newspaper

London

U.S.A.

Rebecca (Mrs.)

unknown

(H) Harold W. Adams, born as 13 above

No

May 21 39

Sept. 18 39

Sept. 18 39

10317

U. S. Naval Hospital

9-18-39

W. H. DUNN, CAPT, USN, Revere, Mass.

Rebecca (Mrs.) 1119 Evergreen Drive, Alexandria, Virginia

Rebecca (Mrs.) 1119 Evergreen Drive, Alexandria, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10324

10340

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>3 days 1 hr. 15 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington San. & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY GARDINER Aiken</u>				4. DATE OF DEATH <u>9 11 1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-99</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>William H. Metzler</u>				14. MOTHER'S MAIDEN NAME <u>EVA McMillan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>204-14-9207</u>		17. INFORMANT <u>Pt's hosp. record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October</u> , 19 <u>59</u> , to <u>Sept 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>59</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				ADDRESS (Street, city or town, state) <u>1019 University Boulevard East</u> DATE SIGNED <u>9/12/59</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>				M.D. <u>Silver Spring Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>9/15/59</u>		<u>SHENNANGO VALLEY CEMETERY</u>		<u>GREENVILLE, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Liska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur A. French</u>			

CERTIFICATE OF DEATH

Form 10-1-1963

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
DATE OF BIRTH [Faint handwritten date]		PLACE OF BIRTH [Faint handwritten place]	
MARRIAGE [Faint handwritten information]		OCCUPATION [Faint handwritten occupation]	
RESIDENCE [Faint handwritten address]		DECEASED AT [Faint handwritten location]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]	
STATE [Faint handwritten state]		ZIP CODE [Faint handwritten zip code]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10378

CERTIFICATE OF DEATH

10325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG R.F.D. # 2 d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LABAN BOGARD ARMSTRONG			4. DATE OF DEATH Month Day Year SEPTEMBER 29 19 59				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/72		9. AGE (In years last birthday) 86		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) VIRGINIA			
13. FATHER'S NAME OLIVER ARMSTRONG			14. MOTHER'S MAIDEN NAME JANE DAVIS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT HOSPITAL RECORDS Address OLNEY, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 days from					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 9/29 , 19 59 to 9/29 , 19 59 , that I last saw the deceased alive on 9/29 , 19 59 , and that death occurred at 8:05A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird		ADDRESS (Street, city or town, state) Sandy Spring, Maryland		DATE SIGNED 9/29/59			
PHYSICIAN'S NAME (Type) J. W. BIRD, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 1 59	22c. NAME OF CEMETERY OR CREMATORY Rockville	22d. LOCATION (City, town, or county) (State) Rockville Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Stacy Barber		ADDRESS Laytonsville Md.	24a. REC'D BY REGISTRAR DATE OCT 2 '59	24b. REGISTRAR'S SIGNATURE Carlton B. Howard			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10326

Reg. Dist. No.

10379

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Mexico b. COUNTY Jal d. STREET ADDRESS Box 635 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frankey Carolyn Awbrey				4. DATE OF DEATH Month Day Year September 4, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 22, 1946	
9. AGE (In years last birthday) 12 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Frank I. Awbrey			
14. MOTHER'S MAIDEN NAME Bertha Gilmore				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebellar Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) Multiple Splenic & Renal Infarction						INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis of Lungs						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 24, 1959 , to September 4, 1959 , that I last saw the deceased alive on September 4, 1959 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 9/4/59							
ACTUAL SIGNATURE Lawrence A. Gaydos PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
SAIPRA		9-4-59		HERMIT, TEXAS			
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co				ADDRESS 1400 Chapin St		24a. REC'D BY REGISTRAR SEP 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

CERTIFICATE OF DEATH

Reg. Dist. No.

10327

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			c. LENGTH OF STAY IN 1b <u>3 YRS</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 BALTIMORE AVE.</u>				d. STREET ADDRESS <u>17300 BALTIMORE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>F.</u> Last <u>BADGER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 12, 1867</u>	
9. AGE (In years lost birthday) yrs. <u>91</u>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>DARLINGTON PENNA.</u>	
13. FATHER'S NAME <u>JAKE FLECHMAN</u>				14. MOTHER'S MAIDEN NAME <u>RHOADES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NINE</u>		17. INFORMANT <u>HOWARD E. CABLE, 248 PARK AVE., TAKOMA PARK, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/27</u> , 19 <u>57</u> , to <u>9/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/18</u> , 19 <u>59</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D. <u>113 CARROLL ST NW. WASH DC 9/26/59</u> PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u> (OVER)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>SEPT. 28, 1959</u>		<u>FT LINCOLN CEMETERY</u>		<u>BLADENSBURG RD. PRINCE GEORGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Harding</u>				ADDRESS <u>254 CARROLL ST. NW. WASH. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Harding</u>	
24a. REC'D BY REGISTRAR <u>SEP 29 '59</u>				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr Brockert, Montgomery County,
Corpus was notified and will

appear.

Deerhart Harding MD

10342

CERTIFICATE OF DEATH

Reg. Dist. No. 10328

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Booz</u> Last <u>Banes</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-94</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claim Settler - Gen. Acct. Off. U.S. Govt. Pa.</u>			11. BIRTHPLACE (State or foreign country) <u>America</u>		
13. FATHER'S NAME <u>Henry Banes</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Harrison</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>WW 2 Army</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelectasis, Rt lung</u> (c) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 wks.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>59</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.			ADDRESS (Street, city or town, state) <u>2701 Canal Ave</u> DATE SIGNED <u>9-14-59</u>		
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pt. Geo. Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hines Co.</u>			ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 16 '59</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

10328

CERTIFICATE OF DEATH

0340

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are handwritten entries in some fields, but they are difficult to decipher due to the quality of the scan.]

10380

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE District of Columbia c. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 1728 Shepard Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle Harwood Last BARRETT				4. DATE OF DEATH Month September Day 23 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-91	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.		11. IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George BARRETT				14. MOTHER'S MAIDEN NAME Danna Godwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1913 -1951			
17. INFORMANT (Wife) Elizabeth (n) Barrett Same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Metastatic Carcinoma of bladder DUE TO (c) years				INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 17 Sept. , 19 59 to 23 Sept. , 19 59 , that I last saw the deceased alive on 23 Sept. , 19 59 , and that death occurred at 4:00 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9-23-59 DATE SIGNED							
ACTUAL SIGNATURE Robert T. Brooks Jr.				M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) Robert T. BROOKS JR. LT. MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave. Bethesda Md. 59				24a. REC'D BY REGISTRAR Arthur E. Kraus			
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10320

Director of Columbia

Washington

U.S. Naval Hospital, Bethesda Md. 1120 Shepard Street

September 23 1952

11-20-51

U.S. Army U.S. Government Virginia U.S.

Donna Godwin

(Wife) Elizabeth (c) Barnett same as 42

1013-1051

IV Rept. 11-23-51

11:00A

U.S. Naval Hospital, Bethesda Md.

Robert T. Brooks Jr. U.S. Naval Hospital, Bethesda Md.

Arlington Virginia

1120 Shepard Ave. Bethesda Md.

10381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Asheville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Asheville			
c. LENGTH OF STAY IN 1b 91 days				d. STREET ADDRESS 110 Annandale Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David Lee Bartlett			4. DATE OF DEATH September 2, 1959			Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1937		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR: Months 2 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant			10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oscar E. Bartlett				14. MOTHER'S MAIDEN NAME Stella Spears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 243-54-9570		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial and subarachnoid hemorrhage DUE TO 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute leukemia DUE TO (c) Septicemia							INTERVAL BETWEEN ONSET AND DEATH 16 hours 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 3, 1959 to September 2, 1959 , that I last saw the deceased alive on September 2, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence A. Gaydos, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-2-59			
PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-3-1959		22c. NAME OF CEMETERY OR CREMATORY Green Hills Cemetery		22d. LOCATION (City, town, or county) (State) Asheville, N C	
23. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home By Manager				ADDRESS Fairfax, Va.		24a. REC'D BY REGISTRAR SEP 8 '59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

225 22

SECRET

10382

CERTIFICATE OF DEATH

Reg. Dist. No.

10331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9011 Old Georgetown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ADENA M. BATES				4. DATE OF DEATH Month Day Year Sept. 19, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 Dec. 31, 1887	9. AGE (In years last birthday) 80 7/8 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 8 18	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Minn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry DeWitz				14. MOTHER'S MAIDEN NAME Hennerita Krigmier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Dorthea H. Townsend-daughter-Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, metastatic of liver 153.8 DUE TO Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Months years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20-59 , to 9-19-59 , that I last saw the deceased alive on 9-15-59 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3701 Conn Circle W.D. Wash. D.C. DATE SIGNED 9-19-59 ACTUAL SIGNATURE C. Roger Kurtz, M.D. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-23-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 24 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur G. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10801

10382



ROBERT A. BOWEN, Secretary, Maryland
Department of Health and Mental Hygiene
Baltimore, Maryland

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 12th inst. regarding the matter of the application for a license to practice medicine and surgery in the State of Maryland.

Very truly yours,
Robert A. Bowen

Enclosed for you are the following documents:

1. Certificate of the State Board of Health.

2. Certificate of the State Board of Medicine.

3. Certificate of the State Board of Surgery.

4. Certificate of the State Board of Dentistry.

5. Certificate of the State Board of Podiatry.

6. Certificate of the State Board of Optometry.

7. Certificate of the State Board of Chiropractic.

8. Certificate of the State Board of Naturopathy.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10383

CERTIFICATE OF DEATH

Reg. Dist. No. **10332**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia				d. STREET ADDRESS R.F.D. Clarksburg			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Barry R. Beall				4. DATE OF DEATH Sept. 10 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Lewisdale, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Cronin Beall				14. MOTHER'S MAIDEN NAME Sally Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-7380		17. INFORMANT Miss Esther W. Beall, Clarksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Cardio-vascular-renal disease. Generalized arteriosclerosis Previous arterial thrombi, as retinal artery, etc. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No injury.						INTERVAL BETWEEN ONSET AND DEATH 1 minute 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1935 , to Sept. 10, 1959 , that I last saw the deceased alive on Sept. 9, 1959 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Druid Theatre Building, Damascus, Maryland. DATE SIGNED 9/11/59							
ACTUAL SIGNATURE M. McKendree Boyer		M.D. Druid Theatre Building, Damascus, Maryland.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/59		22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobaworth		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE SEP 15 59		24b. REGISTRAR'S SIGNATURE Esther W. Beall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10343

CERTIFICATE OF DEATH

10333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 Davis Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>BARNES</u> Last <u>BEAM</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lubrication man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Beam</u>				14. MOTHER'S MAIDEN NAME <u>Alverda W.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-03-9208</u>			
17. INFORMANT Address <u>Mrs. Lucy P. Beam, (same as #2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver & metastasis</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 1, 1959</u> , to <u>5 Sept</u> , 1959, that I last saw the deceased alive on <u>4 Sept</u> , 1959, and that death occurred at <u>1:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. B. Queen</u> M.D. <u>7112 Willow Ave</u>				DATE SIGNED <u>5 Sept 1959</u>			
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll Ave DE</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10384

CERTIFICATE OF DEATH

Reg. Dist. No.

10334

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4702 Highland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUFUS Middle C. Last BEAVERS		4. DATE OF DEATH Month Sept. Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	11. IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-		10b. KIND OF BUSINESS OR INDUSTRY Chestnut Farms Dairy	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Thomas Beavers		14. MOTHER'S MAIDEN NAME Mary Ann ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-03-6506	
17. INFORMANT Wife		Address Same as Item #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO 10 YRS (c) 10 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 YRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25 , 19 59 , to Sept 26 , 19 59 , that I last saw the deceased alive on Sept 25 , 19 59 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo I. Donovan		ADDRESS (Street, city or town, state) DATE SIGNED 8016 Old Georgetown Rd. Bethesda, Md. 9-26-59	
PHYSICIAN'S NAME (Type) LEO I. DONOVAN		Bethesda, Md. 9-26-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-59	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24. REC'D BY REGISTRAR DATE SEP 29 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10334

CERTIFICATE OF DEATH

10334

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED: MONTGOMERY, MARY AND

RESIDENCE: 4702 Highland Ave.

DATE OF DEATH: JAN 20 1937

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

SIGNATURE OF PHYSICIAN: JOHN THOMAS

DATE: JAN 20 1937

REGISTRATION NO. 10334

John Thomas

John Thomas

10334

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10335

Reg. Dist. No.

10385

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Mass b. COUNTY Hampden ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 8 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westfield 58x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Traylor truck) Hamden Lane				d. STREET ADDRESS 11 Palmer Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Honore Middle J Last Begin				4. DATE OF DEATH Month Sept Day 4 Year 19 59				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1898		
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 4 Days 10		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY paper-maker		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes-unknown		17. INFORMANT Alvah Buckner son-in-law				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH subtle	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, lawn, or county) (State)		
Bur-transit		9/4/59		St. Mary's Cemetery		Westfield, Mass.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 8 '59		
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. HENRY		2. SEX Male		3. AGE 45		4. RACE White	
5. PLACE OF BIRTH St. Louis, Mo.		6. DATE OF BIRTH Jan. 15, 1890		7. TIME OF DEATH 11:15 AM		8. DATE OF DEATH Jan. 15, 1935	
9. PLACE OF DEATH Home		10. STREET ADDRESS 1111 N. Ave.		11. CITY Baltimore		12. COUNTY Harford	
13. OCCUPATION None		14. CAUSE OF DEATH Heart Failure		15. MANNER OF DEATH Natural		16. SIGNATURE OF EXAMINER John J. Henry	
17. SIGNATURE OF DECEASED John J. Henry		18. SIGNATURE OF WITNESSES John J. Henry		19. SIGNATURE OF PHYSICIAN John J. Henry		20. SIGNATURE OF JURY John J. Henry	
21. SIGNATURE OF CORONER John J. Henry		22. SIGNATURE OF JURY John J. Henry		23. SIGNATURE OF JURY John J. Henry		24. SIGNATURE OF JURY John J. Henry	
25. SIGNATURE OF JURY John J. Henry		26. SIGNATURE OF JURY John J. Henry		27. SIGNATURE OF JURY John J. Henry		28. SIGNATURE OF JURY John J. Henry	
29. SIGNATURE OF JURY John J. Henry		30. SIGNATURE OF JURY John J. Henry		31. SIGNATURE OF JURY John J. Henry		32. SIGNATURE OF JURY John J. Henry	
33. SIGNATURE OF JURY John J. Henry		34. SIGNATURE OF JURY John J. Henry		35. SIGNATURE OF JURY John J. Henry		36. SIGNATURE OF JURY John J. Henry	
37. SIGNATURE OF JURY John J. Henry		38. SIGNATURE OF JURY John J. Henry		39. SIGNATURE OF JURY John J. Henry		40. SIGNATURE OF JURY John J. Henry	
41. SIGNATURE OF JURY John J. Henry		42. SIGNATURE OF JURY John J. Henry		43. SIGNATURE OF JURY John J. Henry		44. SIGNATURE OF JURY John J. Henry	
45. SIGNATURE OF JURY John J. Henry		46. SIGNATURE OF JURY John J. Henry		47. SIGNATURE OF JURY John J. Henry		48. SIGNATURE OF JURY John J. Henry	
49. SIGNATURE OF JURY John J. Henry		50. SIGNATURE OF JURY John J. Henry		51. SIGNATURE OF JURY John J. Henry		52. SIGNATURE OF JURY John J. Henry	
53. SIGNATURE OF JURY John J. Henry		54. SIGNATURE OF JURY John J. Henry		55. SIGNATURE OF JURY John J. Henry		56. SIGNATURE OF JURY John J. Henry	
57. SIGNATURE OF JURY John J. Henry		58. SIGNATURE OF JURY John J. Henry		59. SIGNATURE OF JURY John J. Henry		60. SIGNATURE OF JURY John J. Henry	
61. SIGNATURE OF JURY John J. Henry		62. SIGNATURE OF JURY John J. Henry		63. SIGNATURE OF JURY John J. Henry		64. SIGNATURE OF JURY John J. Henry	
65. SIGNATURE OF JURY John J. Henry		66. SIGNATURE OF JURY John J. Henry		67. SIGNATURE OF JURY John J. Henry		68. SIGNATURE OF JURY John J. Henry	
69. SIGNATURE OF JURY John J. Henry		70. SIGNATURE OF JURY John J. Henry		71. SIGNATURE OF JURY John J. Henry		72. SIGNATURE OF JURY John J. Henry	
73. SIGNATURE OF JURY John J. Henry		74. SIGNATURE OF JURY John J. Henry		75. SIGNATURE OF JURY John J. Henry		76. SIGNATURE OF JURY John J. Henry	
77. SIGNATURE OF JURY John J. Henry		78. SIGNATURE OF JURY John J. Henry		79. SIGNATURE OF JURY John J. Henry		80. SIGNATURE OF JURY John J. Henry	
81. SIGNATURE OF JURY John J. Henry		82. SIGNATURE OF JURY John J. Henry		83. SIGNATURE OF JURY John J. Henry		84. SIGNATURE OF JURY John J. Henry	
85. SIGNATURE OF JURY John J. Henry		86. SIGNATURE OF JURY John J. Henry		87. SIGNATURE OF JURY John J. Henry		88. SIGNATURE OF JURY John J. Henry	
89. SIGNATURE OF JURY John J. Henry		90. SIGNATURE OF JURY John J. Henry		91. SIGNATURE OF JURY John J. Henry		92. SIGNATURE OF JURY John J. Henry	
93. SIGNATURE OF JURY John J. Henry		94. SIGNATURE OF JURY John J. Henry		95. SIGNATURE OF JURY John J. Henry		96. SIGNATURE OF JURY John J. Henry	
97. SIGNATURE OF JURY John J. Henry		98. SIGNATURE OF JURY John J. Henry		99. SIGNATURE OF JURY John J. Henry		100. SIGNATURE OF JURY John J. Henry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10386

CERTIFICATE OF DEATH

10336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5209 Chandler Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Delbert Mauritz Bergenstal		4. DATE OF DEATH Month Day Year September 12, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1917
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Bergenstal		14. MOTHER'S MAIDEN NAME Stena Jensen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis due to Hypekalemia 580x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post Necrotic Cirrhosis DUE TO (c) Uremia INTERVAL BETWEEN ONSET AND DEATH 24 hours 2½ Years 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal Pyelonephritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1, 19 59 , to September 12, 19 59 , that I last saw the deceased alive on September 12, 19 59 , and that death occurred at 10:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/13/59			
ACTUAL SIGNATURE John P. Utz		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) JOHN P. UTZ, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/16/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

10387

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 32 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY New Martinsville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 d. STREET ADDRESS Northgate Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Lisa		First Jane		Middle Blair		Last Blair		4. DATE OF DEATH Month September Day 1 Year 19 59					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1954		9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Perry D. Blair						14. MOTHER'S MAIDEN NAME Glenna Wagner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Hemorrhages 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Leukemia with Pancytopenia DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 7 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 31 , 19 59 , to September 1 , 19 59 , that I last saw the deceased alive on September 1 , 19 59 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE Lawrence A. Gaydos				M.D. The Clinical Center				9/2/59					
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.				National Institutes of Health Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 9-2-59		22c. NAME OF CEMETERY OR CREMATORY NEW MARTINSVILLE, VA		22d. LOCATION (City, town, or county) (State) WEST					
23. FUNERAL DIRECTOR'S SIGNATURE G.W. Chambers				ADDRESS 1400 Chapin St NW Washington, D.C.		24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10344 CERTIFICATE OF DEATH

10338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u>		c. LENGTH OF STAY IN 1b <u>49 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Sakima Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Washington Sanatorium + Hosp</u>			d. STREET ADDRESS <u>1402 Dulip Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LILLIE E.</u> Middle <u>(initials)</u> Last <u>BLANKS</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-1863</u>	9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Jesse Redgway</u>			14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>8/12</u> , 19 <u>47</u> , to <u>9/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>59</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Dean H. Harding</u>		M.D. <u>113 Carroll St NW Wash DC 9/15/59</u>			
PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>			ADDRESS <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>SEP 17 '59</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

65-11

10388

CERTIFICATE OF DEATH

10339

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>15102 WESSLING LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HERBERT</u> Last <u>BOLAN</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD STA. AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (State or foreign country) <u>IOWA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN BOLAN</u>		14. MOTHER'S MAIDEN NAME <u>BLESSINGTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT Address <u>BETHESDA</u>			
Name <u>Mrs. W. G. Holden</u>		Address <u>5102 Wessling LA-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>2 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/7</u> , 19 <u>58</u> to <u>Sept 1</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>59</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantrant</u> M.D.		ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantrant</u>		DATE SIGNED <u>9/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. Trans.</u>	22b. DATE THEREOF <u>9-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Scranton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Scranton, Iowa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATEMENT OF DEATH

10382

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CERTIFICATE OF DEATH

10340

Reg. Dist. No.

10345

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alfred Ellis Bowers</u>		4. DATE OF DEATH <u>Sept. 20 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-00</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR <u>XXX</u> Months <u>XXX</u> Days <u>XXX</u> Hours <u>XXX</u> Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spec. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FBI</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James R. Bowers, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Winifred HUTCHESON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Washington Sanitarium and Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO (c) <u>Undetermined</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 16, 1959</u> to <u>Sept 20, 1959</u> that I last saw the deceased alive on <u>Sept 20, 1959</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		DATE SIGNED <u>Sept 21 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisk</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATEMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

10389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>14605 HUNT AVENUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>AGEE</u> Last <u>BOWLES</u>		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>XXXXXXXXX William Bowles</u>		14. MOTHER'S MARRIAGE NAME <u>Signora Agee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT (Name and address) <u>MARJORIE H. BOWLES</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA 7 STOMACH</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>3 MONTHS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Sept 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 16</u> , 19 <u>59</u> , and that death occurred at <u>12 M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo I Donovani MD</u>		ADDRESS (Street, city or town, state) <u>8016 Lexington Rd</u>	
PHYSICIAN'S NAME (Type) <u>LEO I DONOVANI MD</u>		DATE SIGNED <u>9/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlino S. Kinas</u>			

1941

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

10382

1

BRANFORD, JAMES

10-10-22

Robert A. Tompkins, Registrar, Springfield, Mass.

10390
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>5 HRS. 20 mins</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VERNE</u> Middle <u>LURA</u> Last <u>BRADSHAW</u>				4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26 1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONARD ?</u>				14. MOTHER'S MAIDEN NAME <u>LUCY MANLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>(HUSBAND)</u> <u>GEORGE L. BRADSHAW</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>2 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 28</u> , 19 <u>59</u> , to <u>Sept 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>59</u> , and that death occurred at <u>BA</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Sharpe m d</u>				ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u> DATE SIGNED <u>9/29/59</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE SHARPE</u>				<u>Kensington, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kinnear</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10330

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10-1-10

10-1-10

10346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				1. d. STREET ADDRESS 3926 Isbell St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Brammer				4. DATE OF DEATH Month Day Year September 23, 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1959		9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY no		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James Duro Brammer				14. MOTHER'S MAIDEN NAME Faith Elaine Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		INFORMANT father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH acute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1959 to Sept 22, 1959 , that I last saw the deceased alive on Sept 21, 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ernest A. Sarao, M.D.				M.D. 7006 New Hampshire Ave., Takoma Park, Md.			
PHYSICIAN'S NAME (Type) Ernest A. Sarao, M. D.				7006 New Hampshire Ave., Takoma Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-24-59		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park 12, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium & Hospital				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Arthur A. Hare	

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OCT 1 59

Arthur A. Hare

CERTIFICATE OF DEATH

10346

10346

10346

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON
JANUARY 1, 1900
DEATH OF
JAMES J. JONES
BORN JANUARY 1, 1870
DIED JANUARY 1, 1900
AGE 30 YEARS
CAUSE OF DEATH
DIPHTHERIA
PLACE OF DEATH
HOSPITAL
CITY
BOSTON
COUNTY
SUFFOLK
STATE
MASSACHUSETTS
REGISTRATION DISTRICT
10346
DEATH OF
JAMES J. JONES
BORN JANUARY 1, 1870
DIED JANUARY 1, 1900
AGE 30 YEARS
CAUSE OF DEATH
DIPHTHERIA
PLACE OF DEATH
HOSPITAL
CITY
BOSTON
COUNTY
SUFFOLK
STATE
MASSACHUSETTS
REGISTRATION DISTRICT
10346

CERTIFICATE OF DEATH

Reg. Dist. No.

10391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Lee</u> Last <u>Broughton</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>June 22, 1861</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Broughton</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Boyle Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Clarence H. Green - 5220 N. Fairfax Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cancer & metastasis to neck.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22</u> 19 <u>59</u> , to <u>9-26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>9-25</u> 19 <u>59</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D.		ADDRESS (Street, city or town, state) <u>10128 Cedar Lane Kensington, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover, M. D.</u>		DATE SIGNED <u>9-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Tucker & Sons - Rea</u>		ADDRESS <u>17th</u>	
24a. REC'D BY REGISTRAR <u>SEP 30 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1850

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 10345

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 5911 Dick Street, N.E.	
3. NAME OF DECEASED (Type or print) Bessie Lee Brown		4. DATE OF DEATH September 29, 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Watson		14. MOTHER'S MAIDEN NAME Alice Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure, Pulmonary Edema, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma, Pulmonary & Anemia; Uremia DUE TO Obstruction. (c) Carcinoma of Cervix, Uteri and Bilateral Uteral		INTERVAL BETWEEN ONSET AND DEATH 15 Minutes 3-5 Weeks 6-8 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1959 , to September 29, 1959 , that I last saw the deceased alive on September 29, 1959 , and that death occurred at 12:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/30/59 ACTUAL SIGNATURE Alan B. Retik M.D. National Institutes of Health PHYSICIAN'S NAME (Type) ALAN B. RETIK, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-3-59		22b. DATE THEREOF 10-3-59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, 389-R.D. Ave. NW		24a. REC'D BY REGISTRAR DATE 2/59	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

The Clinical Center, Baltimore, Md. 1001 Park Street, N.W. Washington, D.C.		Date of Death: September 22, 1952	
Name: Robert Taylor		Sex: Male	
Race: White		Age: 35	
Birth Date: September 22, 1917		Birth Place: Washington, D.C.	
Usual Residence: Washington, D.C.		Present Residence: Washington, D.C.	
Cause of Death: Myocardial Infarction		Contributing Cause: Coronary Artery Disease	
Immediate Cause: Myocardial Infarction		Underlying Cause: Coronary Artery Disease	
Manner of Death: Natural		Place of Death: The Clinical Center, Baltimore, Md.	
Physician: Dr. Robert Taylor		Hospital: The Clinical Center, Baltimore, Md.	
Date of Death: September 22, 1952		Time of Death: 10:00 A.M.	
Signature of Physician: Robert Taylor		Signature of Registrar: [Signature]	
Date of Death: September 22, 1952		Time of Death: 10:00 A.M.	
Signature of Physician: Robert Taylor		Signature of Registrar: [Signature]	
Date of Death: September 22, 1952		Time of Death: 10:00 A.M.	
Signature of Physician: Robert Taylor		Signature of Registrar: [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10346

10393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Summit Point			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Summit Point 85 x - 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERTRUDE		First Middle Last BROWN		4. DATE OF DEATH Month Sept Day 16 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 12-1871		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 11 Days 4 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Jefferson Co., West Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Brotherton				14. MOTHER'S MAIDEN NAME Mary Jane Spotts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Asbury Methodist Home Records Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive cardiovascular disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-8 , 19 58 , to 9-16 , 19 59 , that I last saw the deceased alive on Sept 16 , 19 59 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10128 CEDAR LAKE KENSINGTON, MD DATE SIGNED 9-16-59							
ACTUAL SIGNATURE Sarah E. Glover		M.D. 10128 CEDAR LAKE KENSINGTON, MD					
PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Berryville Va	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gastner				ADDRESS Gaithersburg Md		24a. REC'D BY REGISTRAR DATE SEP 18 59	
				24b. REGISTRAR'S SIGNATURE Arthur A. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Test

Sept 16
March 3

8-8
10
1949

1948 Cedar Lake
Reservoir, Mich.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 10347											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow/ Olney			c. LENGTH OF STAY IN lb 33 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow, Rt. 116				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hosp. Inc.					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) First Guy Middle Leroy Last Brown					4. DATE OF DEATH Month September Day 18 Year 19 59						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/99		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscapist			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harry Brown					14. MOTHER'S MAIDEN NAME Maude Johnson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Olney, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 33 hrs. 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) Inter-capsular hemorrhage-lt.kidney 33 hrs. (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of pelvis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Truck backed over him while attempting to close a gate								
20c. TIME OF INJURY Month, Day, Year Hour 3:15 P. m. 9/16 19 59			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Unity, Montg. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Frank J. Broschart,					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9/18/59						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Sept 21		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion			22d. LOCATION (City, town, or county) (State) Highland Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md					24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10348

10395

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		c. LENGTH OF STAY IN 1b 48 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katie Middle Duncan Last Buckley		4. DATE OF DEATH Month Sept. Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/78
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 24 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elzie Duncan Shackelford		14. MOTHER'S MAIDEN NAME Annie Mae Balthrope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis + Myocardial Infarction + auricular Fibrillation DUE TO (c) 48 hrs. INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 Sept , 19 59 , to 24 Sept , 19 59 , that I last saw the deceased alive on 24 Sept , 19 59 , and that death occurred at 1 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Md. DATE SIGNED 24 Sept 59			
ACTUAL SIGNATURE John Bosley Ziegler M.D.		PHYSICIAN'S NAME (Type) JOHN BOSLEY ZIEGLER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR SEP 28 '59 24b. REGISTRAR'S SIGNATURE C. H. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10349

10347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Albert</u> Last <u>Burdis</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN BLDG TRADES</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A Burdis, sr.</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-03-9370</u>	
INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Heart Block-complete</u> DUE TO (c) <u>7 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 26, 1959</u> , to <u>Sept 27, 1959</u> , that I last saw the deceased alive on <u>Sept 27, 1959</u> , and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Tak. Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		DATE SIGNED <u>9/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>GEN. RIGGS RD. HYATTSVILLE, PRGEORG., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Walters</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>254 Conwell St. Wash. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Walters</u>	

SEP 29 59

10830

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10830

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored and appears to be bleed-through from the reverse side of the page.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350

10396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland (Rural) c. LENGTH OF STAY IN 1b 75 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fairland (Rural) d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Katie Middle Burton Last Burton		4. DATE OF DEATH Month Sept. Day 4 Year 59				
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6 1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Jackson			14. MOTHER'S MAIDEN NAME Martha Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		INFORMANT Dora Williams Silver Spring, Md. Route 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma Epileptiform Seizures 442X DUE TO Hemiplegia (old) Cardiorenal Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (b) Arteriosclerosis Hypertension DUE TO (c) Arteriosclerosis Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis Fibroid Tumor Uterus						INTERVAL BETWEEN ONSET AND DEATH 5 day 7 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 29 , 19 39 , to Sept. 4 , 19 59 , that I last saw the deceased alive on Sept. 4 , 19 59 , and that death occurred at 12:15 M. From the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck, Rt. 1 Silver Spring, Md. DATE SIGNED 98.59 ACTUAL SIGNATURE Webster Sewell M.D. PHYSICIAN'S NAME (Type) Webster Sewell, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)
DOKIAL		9-8-59		ROUND OAK		Spencerville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden		ADDRESS Rockville, Md		24a. RECEIVED BY REGISTRAR SEP 10 59		24b. REGISTRAR'S SIGNATURE Arthur E. Evans

10320

CERTIFICATE OF DEATH

10320

Full Name (Printed) _____
Sex _____ Age _____
Date of Birth (Month) _____ (Day) _____ (Year) _____
Place of Birth _____

Occupation _____
Usual Residence _____

Deceased _____
Cause of Death _____
U. S. S. _____

George Jackson _____
Date of Death _____
Place of Death _____

Medical History _____
Cause of Death _____
U. S. S. _____

Medical History _____
Cause of Death _____
U. S. S. _____

Medical History _____
Cause of Death _____
U. S. S. _____

Medical History _____
Cause of Death _____
U. S. S. _____

Medical History _____
Cause of Death _____
U. S. S. _____

Medical History _____
Cause of Death _____
U. S. S. _____

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10348

CERTIFICATE OF DEATH

10351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery PG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George Hyattsville 1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sant.		d. STREET ADDRESS 1100 Chillum Minor Dr	
3. NAME OF DECEASED (Type or print) First GRACE Middle M Last CAPONE		4. DATE OF DEATH Month Sept. Day 23, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	9. AGE (In years last birthday) yrs. 72
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Morfesi		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Angeline Jackerson 1100 Chillum Minor Dr		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hypertensive Hem. Dis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 17, 1959 , to Sept 20, 1959 , that I last saw the deceased alive on Sept 20, 1959 , and that death occurred at 2:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edw. J. Hoffman		ADDRESS (Street, city or town, state) DATE SIGNED 9-5-1959 Dr. N.W. Weber DC	
PHYSICIAN'S NAME (Type) LEDOYER SCHULTAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Ga. Ave. Wash.		24a. REC'D BY REGISTRAR SEP 25 '59	
24b. REGISTRAR'S SIGNATURE Carlton L. F...			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
JAMES EARL RAY		Male		White		April 22, 1928		April 4, 1968	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
Memphis, Tennessee		1100 Clinton Street, N.W.		Suicide		Suicide		[Signature]	
11. Signature of Registrar		12. Signature of Medical Examiner		13. Signature of Coroner		14. Signature of Burial Director		15. Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. Name of Funeral Home		17. Name of Burial Place		18. Name of Cemetery		19. Name of Interment		20. Name of Undertaker	
[Name]		[Name]		[Name]		[Name]		[Name]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

CERTIFICATE OF DEATH

Reg. Dist. No.

10352

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 80 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills d. STREET ADDRESS 5117 Benning Road, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kathryn Middle Mary Last Cappelli		4. DATE OF DEATH Month September Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1956
9. AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 16 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Cappelli		14. MOTHER'S MAIDEN NAME Pauline Hnylanski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) Bronchopneumonia, left upper lobe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, left upper lobe		INTERVAL BETWEEN ONSET AND DEATH 10 min. 11 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1959 , to September 26, 1959 , that I last saw the deceased alive on September 26, 1959 , and that death occurred at 1:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-26-59			
ACTUAL SIGNATURE Richard C. Mechanic PHYSICIAN'S NAME (Type) Richard C. Mechanic, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/29/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 517-11th St. S.E. Wash., D.C.		24a. REC'D BY REGISTRAR DET 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

10398

CERTIFICATE OF DEATH

Reg. Dist. No.

10353

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 14 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 621 RAY DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M Last CARPENTER		4. DATE OF DEATH Month Sept Day 19 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 2 Min.	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (retired)		10b. KIND OF BUSINESS OR INDUSTRY G.A.O.	11. BIRTHPLACE (State or foreign country) MASS.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES CARPENTER	
14. MOTHER'S MAIDEN NAME MARIAM MARGAND		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Maude R. Carpenter, 621 Ray Drive Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Memia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Renal Disease (c) Small atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subacute ulcer, Secondary tumor 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 17, 1958 to Sept 19, 1959 that I last saw the deceased alive on Sept 16, 1959 and that death occurred at 4:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5601 - 4 St NW Washington DC DATE SIGNED Sept 20/59			
ACTUAL SIGNATURE J. H. Courtney M.D.		PHYSICIAN'S NAME (Type) F. X. COURTNEY M.D. Washington DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE SEP 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

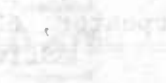
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CERTIFICATE OF DEATH

10393

10393



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10354

10399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MONTGOMERY b. COUNTY MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Carter				4. DATE OF DEATH Month SEPTEMBER Day 20 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/19/59	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE NOLEN CARTER				14. MOTHER'S MAIDEN NAME HELEN CHRISTINE ROGERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 9/19 , 19 59 , to 9/20 , 19 59 , that I last saw the deceased alive on 9/20 , 19 59 , and that death occurred at 8:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/20/59							
ACTUAL SIGNATURE B. Meadors M.D.				PHYSICIAN'S NAME (Type) G. F. MEADORS, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Sept. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY DARNESTOWN Presby Cem	
22d. LOCATION (City, town, or county) DARNESTOWN, MD				22e. REC'D BY REGISTRAR SEP 24 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kline	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Md							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>17 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8310 16th STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>ESTELLE</u> Last <u>CASHELL</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 20, 1871</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>GEORGE M. CECIL</u>				14. MOTHER'S MAIDEN NAME <u>SARAH J. ROEKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>MARY LEE CASHELL</u> Address <u>AS ABOVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>CEREBRAL ATHEROSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 YEARS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>SEPT. 9</u> , 19 <u>57</u> , to <u>SEPT. 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT. 3</u> , 19 <u>59</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE</u> <u>SEPT. 3, 1959</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINNESOTA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

10000

10000

1

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10356**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b few hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8009 Kentucky Dr		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Montg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 3704 Manor Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laban Christopher Chappell First Middle Last 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-15-1901 9. AGE (In years last birthday) 57 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt 10b. KIND OF BUSINESS OR INDUSTRY Fed Housing 11. BIRTHPLACE (State or foreign country) S.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		4. DATE OF DEATH Sept 14 1959 Month Day Year 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME Laban C. Chappell 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Isabel Chappell - Sister I		14. MOTHER'S MAIDEN NAME Martin Ann Montiphi 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 974X Conditions, if any, which gave rise to immediate cause (b) hanging (c) ! PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) hung self by neck in sister's home 20c. TIME OF INJURY Month, Day, Year 9-14 1959 Hour o. m. pm 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) Bethesda (County) Montg (State) md		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE Frank J. Broschert EXAMINER'S NAME (Type) FRANK J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/17/59 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 22d. LOCATION (City, town, or county) Rockville, Maryland		24a. REC'D BY REGISTRAR SEP 17 '59 24b. REGISTRAR'S SIGNATURE Arthur E. Huns	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10050

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10001

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF REINTERMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10402

CERTIFICATE OF DEATH

Reg. Dist. No.

10357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Chester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paoli</u>	
c. LENGTH OF STAY IN 1b <u>1 yr.</u>		d. STREET ADDRESS <u>5454 Jolina Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Martin</u> Last <u>Church</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 24, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Music</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Phillip Church</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Robt. Walker</u>		Address <u>7103 Fla. St. Ch. Ch. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 hr</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7 July, 1959</u> to <u>28 Sept, 1959</u> , that I last saw the deceased alive on <u>Sept 28, 1959</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D.		ADDRESS (Street, city or town, state) <u>Burtonsville, Md</u> DATE SIGNED <u>9-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons, Jr MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Sept. 28 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belvidere</u>	22d. LOCATION (City, town, or county) (State) <u>Belvidere Penn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Saylorsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Harris</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1950"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]	
SIGNATURE OF CLERK [Faint text, possibly "Mary White"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Brown"]		SIGNATURE OF JUDGE [Faint text, possibly "Hon. John Black"]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

10403

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle d. STREET ADDRESS 31 Mason Dr., Thomason Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Daniel Middle Guy Last CILLEY		4. DATE OF DEATH Month September Day 15 Year 1959		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-59		9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1		11. IF UNDER 24 HRS. Days 22 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Herbert Leo CILLEY						14. MOTHER'S MAIDEN NAME Marie Elizabeth SIMARD											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				INFORMANT (F) Herbert L. Cilley, same as #2				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral polycystic kidney disease DUE TO From birth (c) -----																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Sept. 1 , 19 59 , to Sept. 15 , 19 59 that I last saw the deceased alive on Sept. 15 , 19 59 , and that death occurred at 1240AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 9-15-59 ACTUAL SIGNATURE Robert T. Brooks Jr. M.D. PHYSICIAN'S NAME (Type) Robert T. BROOKS, Jr., LT, MC, Bethesda, Maryland																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-16-59				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Falmouth Maine					
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd.				ADDRESS Arlington, Va.				24a. REC'D BY REGISTRAR DATE SEP 18 '59				24b. REGISTRAR'S SIGNATURE C. E. K. K.					

9VVVVVVVVVV

10503

10503

10503

Virginia

Montgomery

Travis

14 days

Bernardo (Hunt)

31 Mason Dr., Thompson Park

U. S. Naval Hospital

CILLEY

COY

Daniel

1 SS

7-23-52

Caucasian

Male

U.S.A.

Virginia

Marie Elizabeth Smith

Harvey Lee Smith

(M) Robert E. Smith, same as M

None

No

14 days

Uremia

Chronic glomerulonephritis

29 Sept. 52

Sept. 52

Sept. 52

U. S. Naval Hospital

Robert T. Brooks, Jr., Lt. MC, Bethesda, Maryland

None

Virginia

Williamson, Va.

10503

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10404

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 41 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emory Middle Fitch Last CLEMENT		4. DATE OF DEATH Month September Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-87
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maynard CLEMENT		14. MOTHER'S MAIDEN NAME Clara FITCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & II	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA ± METASTASES 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH ± MULTIPLE 6 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE ± SEVERE CONGESTIVE FAILURE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30 , 19 59 , to Sept. 9 , 19 59 , that I last saw the deceased alive on Sept. 8 , 19 59 , and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. S. Caldwell		DATE SIGNED 9-9-59	
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR SEP 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10004

Verdine

Birthdate

41 days

Birthdate (month)

U. S. Naval Hospital

420 Madison Ave.

September 9, 1950

CLINICAL

Physician

History

Name

Constitution

11-17-50

New York

U.S. Navy

History

CLINICAL PHYSICIAN

Maxwell Clement

Hospital Records

Yes W1 & II

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Sept. 9, 1950

July 30

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U. S. Naval Hospital

Coronado 14, Maryland

LTJG, USN

U. S. LARKIN, LTJG, USN

Maryland

Operation 2-10-50, Camp Hill Cemetery, Maryland

U.S. Navy, Bureau of Naval Medicine, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10360

10405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>		d. STREET ADDRESS <u>1 12225 Selfridge Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Dora</u> Last <u>Clore</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasia</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 20, 1900</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Madison Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACKSON GOAR</u>		14. MOTHER'S MAIDEN NAME <u>Sarah May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>579-24-529</u>	
17. INFORMANT <u>Mrs Harold Hyre</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma, Lung, Right</u> DUE TO (c) <u>Branchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Sep 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sep 15</u> , 19 <u>59</u> , and that death occurred at <u>7:10 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u> M.D.		ADDRESS (Street, city or town, state) <u>10609 Concord Street</u>	
DATE SIGNED <u>Sep 16, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>		<u>Kensington, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>PR. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., 1400 Chapin St., N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

CERTIFICATE OF DEATH

10361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
c. LENGTH OF STAY IN 1b 3 yrs 6 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Avenue		d. STREET ADDRESS 3000 McComas Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Solon Cooper		4. DATE OF DEATH Sept 14th 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-1871
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hotel Business Wash, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Cooper		14. MOTHER'S MAIDEN NAME Josephine Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT 5326 Willard Ave		June C. Reynolds Chevy Chase, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis Arterio- DUE TO Sclerotic Disease (c) Carcinoma of the Colon			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 to Sept 14th , 19 59 that I last saw the deceased alive on Sept 13th , 19 59 , and that death occurred at 2:05 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8106 Maple Ridge Road DATE SIGNED 9-14-59			
ACTUAL SIGNATURE W.T. Joyce		M.D. Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) W.T. Joyce			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-1959	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		ADDRESS 131-11 50th	
24a. REC'D BY REGISTRAR SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10362

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE New York b. COUNTY ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 3½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Levittown 69x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 19 Abbey Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lucy Middle Creamer Last				4. DATE OF DEATH Month Sept Day 20 Year 1959				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April ? 1921		
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sudduth				14. MOTHER'S MAIDEN NAME Lena Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Alice P. Bean, 7019 Ga. Ave., Silver Spring Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Spleen DUE TO (c) Automobile accident INTERVAL BETWEEN ONSET AND DEATH 3½ hours 3½ hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple fractures, head injuries, internal injuries								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident						
20c. TIME OF INJURY Month, Day, Year 12:20 p.m. 9/20/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Bethesda Montg. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9/20/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24/1959		22c. NAME OF CEMETERY OR CREMATORY Long Island National Cemetery Farmingdale, Long Island, N.Y.		22d. LOCATION (City, town, or county) (State) Long Island, N.Y.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol 2224 - Wis. Ave. D.C.				24a. REC'D BY REGISTRAR SEP 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

PHYSICIAN'S EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of examiner		11. Date of examination		12. Place of examination	
13. Name of hospital		14. Name of physician		15. Name of examiner	
16. Name of hospital		17. Name of physician		18. Name of examiner	
19. Name of hospital		20. Name of physician		21. Name of examiner	
22. Name of hospital		23. Name of physician		24. Name of examiner	
25. Name of hospital		26. Name of physician		27. Name of examiner	
28. Name of hospital		29. Name of physician		30. Name of examiner	
31. Name of hospital		32. Name of physician		33. Name of examiner	
34. Name of hospital		35. Name of physician		36. Name of examiner	
37. Name of hospital		38. Name of physician		39. Name of examiner	
40. Name of hospital		41. Name of physician		42. Name of examiner	
43. Name of hospital		44. Name of physician		45. Name of examiner	
46. Name of hospital		47. Name of physician		48. Name of examiner	
49. Name of hospital		50. Name of physician		51. Name of examiner	
52. Name of hospital		53. Name of physician		54. Name of examiner	
55. Name of hospital		56. Name of physician		57. Name of examiner	
58. Name of hospital		59. Name of physician		60. Name of examiner	
61. Name of hospital		62. Name of physician		63. Name of examiner	
64. Name of hospital		65. Name of physician		66. Name of examiner	
67. Name of hospital		68. Name of physician		69. Name of examiner	
70. Name of hospital		71. Name of physician		72. Name of examiner	
73. Name of hospital		74. Name of physician		75. Name of examiner	
76. Name of hospital		77. Name of physician		78. Name of examiner	
79. Name of hospital		80. Name of physician		81. Name of examiner	
82. Name of hospital		83. Name of physician		84. Name of examiner	
85. Name of hospital		86. Name of physician		87. Name of examiner	
88. Name of hospital		89. Name of physician		90. Name of examiner	
91. Name of hospital		92. Name of physician		93. Name of examiner	
94. Name of hospital		95. Name of physician		96. Name of examiner	
97. Name of hospital		98. Name of physician		99. Name of examiner	
100. Name of hospital		101. Name of physician		102. Name of examiner	

10408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLONIAL HEIGHTS 83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital			d. STREET ADDRESS 148 Roanoke Avenue		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DAVID Middle T. Last CREIGHTON			4. DATE OF DEATH Month SEPTEMBER Day 18 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/81	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Liverpool, England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JONATHAN CREIGHTON			14. MOTHER'S MAIDEN NAME Sarah unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. no		
17. INFORMANT Mrs. W. L. Douglas, Olney, Maryland			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive GI Hemorrhage 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD - hypertension					
INTERVAL BETWEEN ONSET AND DEATH 6 hrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8-5 , 19 59 , to 9-18 , 19 59 , that I last saw the deceased alive on 9-18 , 19 59 , and that death occurred at 2:10 PM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 4404 Greenbury Rd Riverdale Md					
DATE SIGNED					
ACTUAL SIGNATURE Roy B Parsons Jr M.D.					
PHYSICIAN'S NAME (Type) Roy B Parsons Jr					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
TRANS. & BURIAL		9/18/59		Colonial Heights, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 21 '59	
				24b. REGISTRAR'S SIGNATURE Cribbs & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10883

CERTIFICATE OF DEATH

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NO. 10883

ATTEST

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10364

10409

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 116 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worcester 58X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle (none) Last Cronin		4. DATE OF DEATH Month September Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY City Ordinance	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Cronin		14. MOTHER'S MAIDEN NAME Mary Donahue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 034-09-7771	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and Cardiac Insufficiency 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma to lungs + heart DUE TO (c) Carcinoma of the Pancreas		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1959 , to September 30, 1959 , that I last saw the deceased alive on September 30, 1959 , and that death occurred at 7:01 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/30/59			
ACTUAL SIGNATURE Leon Rosenberg		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Leon Rosenberg, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR. 9-30-1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) WORCESTER MASS	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS 1400 Chapin St NW	
24a. REC'D BY REGISTRAR OCT 5 1959		24b. REGISTRAR'S SIGNATURE Arthur B. Hanna	

10408

Montgomery

Bedford

115 days

Worcester

The Clinical Center, Bethesda Md., Md.

10 Standard Unit

Michael

(none)

Growth

September

22

Male

White

November 2, 1952

22

Canadian

City Ordinance

Ireland

U. S. A.

Daniel Brown

Mary Louisa

The Medical Record,

The Clinical Center, Bethesda Md., Maryland

031-02-7777

No

September 30, 52

June 6,

1951

22

September 30,

The Clinical Center
National Institutes of Health
Bethesda Md., Maryland

Leon Rosenberg, M.D.

10410

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 82 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 3902 Aspen Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clara		First Mae		Middle CRITCHFIELD		Last CRITCHFIELD		4. DATE OF DEATH Month September Day 24 Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-86		9. AGE (In years lost birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George PRINCE				14. MOTHER'S MAIDEN NAME Maryette SPURGEON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service.		16. SOCIAL SECURITY NO. 577 01 6081		INFORMANT Address (Daughter) Ruth C. REID Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 July , 19 59 to 24 Sept , 19 59 that I last saw the deceased alive on 24 September , 19 59 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md.									
ACTUAL SIGNATURE C. G. Muth				M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN				U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-59		22c. NAME OF CEMETERY OR CREMATORY Ripley Cemetery		22d. LOCATION (City, town, or county) (State) Big Prairie Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Burt				ADDRESS 4414		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur J. Kram	
Chamber Funeral Home 3072 "M" Street Washington D.C.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 30 '59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10366

10411

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC. Box 69				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. STREET ADDRESS Box 69 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GLADYS JENNETTE CROSBY				4. DATE OF DEATH Month Day Year SEPTEMBER 20 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/09	
9. AGE (In years last birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years last birthday) 50 yrs.	
11. BIRTHPLACE (State or foreign country) NEW YORK				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES GARFIEDL DEGARMO				14. MOTHER'S MAIDEN NAME LILLIAN VIOLA SPEED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 046-20-2515		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ben. Ca. = Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inflammatory Ca. Rt. Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6. mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 March, 1959 , to 20 Sept, 1959 , that I last saw the deceased alive on 19 Sept, 1959 , and that death occurred at 5:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Md. DATE SIGNED 21 Sept 59 ACTUAL SIGNATURE John Bozley Ziegler M.D. M.D. PHYSICIAN'S NAME (Type) J. B. ZIEGLER, M.D. OLNEY, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montg. Ave/ Rockville, Md.				24a. REC'D BY REGISTRAR DATE SEP 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10412

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turtle Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 350 McMasters Ave.	
3. NAME OF DECEASED (Type or print) First Donald Middle Carl Dunn Last CURRIE		4. DATE OF DEATH Month September Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-40
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James G. CURRIE		14. MOTHER'S MAIDEN NAME Dolores J. DUNN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 203-30-3419	
17. ADDRESS Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widely disseminated sarcoma DUE TO Sarcina Reticulum Cell type Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2 , 19 59 , to September 7, 1959 , that I last saw the deceased alive on September 6 , 19 59 , and that death occurred at 11:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 9-8-59 ACTUAL SIGNATURE William P. Baker PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-9-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Turtle Creek, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chmabers & Co., 1400 Chapin St., N.W.		24a. REC'D BY REGISTRAR DATE SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10415

CERTIFICATE OF DEATH

10415

Montgomery	17 days	210 Montgomery Ave.	10415
Westchase (Harris)			
U.S. Naval Hospital			
Donald	Carl Dean		
Male	1-2-40		
Mexico	U.S. Marine Corps		
James C. CURRIE			
Yes	9-19-48 to BOX 203-30-310	Hospital Records	

James C. Currie
U.S. Marine Corps
Westchase, Harris
1-2-40

September 8 1948
 U.S. Naval Hospital
 William P. Walker, Lt. MC, USN
 Westchase, Harris
 1-2-40
 11-40
 10415

CERTIFICATE OF DEATH

10368

Reg. Dist. No.

10413

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) unobtainable X Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Primrose Street		d. STREET ADDRESS 106 Primrose Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle A. Last CURTISS		4. DATE OF DEATH Month 9 Day 30 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hoch		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Charles Lewis Curtiss		Address Chevy Chase, Md. 106 Primrose St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart disease (c) Cardio Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 4 HRS. 8 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 10 1954 to Sept 30 1959 that I last saw the deceased alive on Sept 28 1959 and that death occurred at 4:43 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. F. Quaxle M.D.		ADDRESS (Street, city or town, state) 1922 Biltmore St. NW Washington D.C.	
DATE SIGNED Sept 30 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR OCT 5 1959	
24b. REGISTRAR'S SIGNATURE Arthur G. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1898

CERTIFICATE OF DEATH

10413

Page Two

1. NAME OF DECEASED John McKee		2. SEX Male		3. AGE 40		4. DATE OF BIRTH 1858		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. CAUSE OF DEATH Typhoid fever		8. DATE OF DEATH 1898		9. PLACE OF DEATH Home		10. SIGNATURE OF PHYSICIAN J. H. Jones	
11. SIGNATURE OF WITNESSES J. H. Jones, M.D. J. H. Jones, M.D.		12. SIGNATURE OF DECEASED John McKee		13. SIGNATURE OF NEAREST RELATIVE John McKee		14. SIGNATURE OF CLERK J. H. Jones		15. SIGNATURE OF REGISTRAR J. H. Jones	
16. SIGNATURE OF DECEASED John McKee		17. SIGNATURE OF NEAREST RELATIVE John McKee		18. SIGNATURE OF CLERK J. H. Jones		19. SIGNATURE OF REGISTRAR J. H. Jones		20. SIGNATURE OF DECEASED John McKee	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. DATE OF DEATH
9. PLACE OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF WITNESSES
12. SIGNATURE OF DECEASED
13. SIGNATURE OF NEAREST RELATIVE
14. SIGNATURE OF CLERK
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF DECEASED
17. SIGNATURE OF NEAREST RELATIVE
18. SIGNATURE OF CLERK
19. SIGNATURE OF REGISTRAR
20. SIGNATURE OF DECEASED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10369

10349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 3 1/2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON SAN. HOSPITAL				d. STREET ADDRESS 14614 ASPEN HILL CT.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER GERALD DEGROUCHY				4. DATE OF DEATH Month Day Year 9 26 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 7 1959	
9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months Days Hours Min. 19		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		13. FATHER'S NAME WALTER DE GROUCHY	
14. MOTHER'S MAIDEN NAME ISABEL DEAN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. -				17. INFORMANT Address HOSPITAL RECORDS W.S.H.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.3 DUE TO Congenital hypoplasia of kidneys, not complicated by electrolyte imbalance + acidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO - (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - (b) - (c) -							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -				20g. (County) -		20h. (State) -	
21. I certify that I attended the deceased from 9/22 , 19 59 , to 9/26 , 19 59 , that I last saw the deceased alive on 9/26 , 19 59 , and that death occurred at 11:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Coleman MD				ADDRESS (Street, city or town, state) 733 Sleeps Avenue			
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN				DATE SIGNED 9/26/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9-28-1959		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Spall's Funeral Home Mt. Rainier				ADDRESS 2075 234 XUV		24a. REC'D BY REGISTRAR SEP 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kline							

CERTIFICATE OF DEATH

10842

DATE OF DEATH

PLACE TO BE FILLED BY REGISTRAR

NAME OF DECEASED

AGE OF DECEASED AT DEATH

SEX OF DECEASED

RACE OF DECEASED

EDUCATION OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISSECTION

NAME OF ANATOMY

NAME OF PATHOLOGY

NAME OF RADIOLOGY

NAME OF SURGERY

NAME OF DENTISTRY

NAME OF OPTOMETRY

NAME OF PODIATRY

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF ASSISTANT

NAME OF ATTENDING

NAME OF WITNESS

NAME OF SIGNATURE

NAME OF PRINT

10350

CERTIFICATE OF DEATH

Reg. Dist. No.

10370

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>81 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Catherine</u> Last <u>Dinsmore</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-12-98</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>61</u> Days <u>800</u>	IF UNDER 24 HRS. Hours <u>61</u> Min. <u>800</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin. Ass't.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Admin. Asst. U.S. Dept of Agric.</u>		11. BIRTHPLACE (State or foreign country) <u>Amer. Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>William Ewertz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kirschel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>abdominal adenocarcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic pleural adenocarcinoma</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 20</u> , 19 <u>59</u> , to <u>Sept 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George William Ware</u> M.D.				ADDRESS (Street, city or town, state) <u>900-17th St. W Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE WILLIAM WARE</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10371

10414

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs, Md		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Philmena rest home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winifred Middle H. Last Dobrin		4. DATE OF DEATH Month Sept Day 18 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James C. Higgins		14. MOTHER'S MAIDEN NAME Mary J. Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Marie D Mc Callam		Address Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Disease DUE TO (c) approx 25 yrs.			INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-11-1959 to 9-18-1959 that I last saw the deceased alive on 9-18-1959 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 9/18/59			
ACTUAL SIGNATURE F. Gasch M.D.		PHYSICIAN'S NAME (Type) Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/59	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10415

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY Columbus c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbus d. STREET ADDRESS 511 First Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carl Ernest DOOLEY		4. DATE OF DEATH Month Day Year September 6 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 14 April 1916
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY k	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isom DOOLEY		14. MOTHER'S MAIDEN NAME Lola TURNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT 311 Courtney Drive William H. RAFFEL Triangle, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic Insufficiency (c) Hepatic Cirrhosis Chronic Alcoholism		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 August, 19 59 to 6 Sept., 19 59 that I last saw the deceased alive on 6 September, 19 59 , and that death occurred at 4:40 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 9-7-59			
ACTUAL SIGNATURE William P. Baker		PHYSICIAN'S NAME (Type) William P. BAKER LT MC USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/59	
22c. NAME OF CEMETERY OR CREMATORY Garland Brook		22d. LOCATION (City, town, or county) (State) Columbus Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Adams		24a. REC'D BY REGISTRAR Arthur S. Kneass	
24b. REGISTRAR'S SIGNATURE Adams Funeral Home 4748 Wisconsin Ave. N.W. Washington, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10418

Montgomery

Edwards (Thurs)

U.S. Naval Hospital, Bethesda, Md.

Carl

Male

Priorities

Jack DOOLEY

No

William H. Turner, Triangle, Virginia

Handwritten signature and notes

19 August 59 9 Sept.

September 59

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10416

CERTIFICATE OF DEATH

10373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>16 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea-Woodland Nursing Home</u>				d. STREET ADDRESS <u>3608 9th St. So.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Kathlein</u> Last <u>Dorn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1878</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Cervi</u>				14. MOTHER'S MAIDEN NAME <u>Kathlein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Edward Dorn</u>				Address <u>5307 S.D. Ave. N.E. Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral infarct</u> DUE TO (c) <u>Cerebral thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>Sept. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>59</u> , and that death occurred at <u>2:58</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u>				ADDRESS (Street, city or town, state) <u>6480 New Hampshire Ave.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein M.D.</u>				<u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/25/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur & Hume</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED: ALFRED J. BROWN

2. SEX: MALE

3. AGE: 45

4. DATE OF BIRTH: 1900

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: CLERK

7. CAUSE OF DEATH: HEART DISEASE

8. PLACE OF DEATH: HOME

9. TIME OF DEATH: 10:30 AM

10. SIGNATURE OF PHYSICIAN: [Signature]

11. SIGNATURE OF REGISTRAR: [Signature]

12. DATE OF REGISTRATION: 1945

1

RECEIVED
BUREAU OF VITAL STATISTICS
JAN 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10374

10417

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home				d. STREET ADDRESS 3725 Macomb Street, N. W.			
3. NAME OF DECEASED (Type or print) EVA First STIDHAM Middle DOUGALL Last				4. DATE OF DEATH September 12 1959 Month September Day 12 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George K. Stidham				14. MOTHER'S MAIDEN NAME Hannah M. Gardiner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 3725 Macomb St., N. W. Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CHRONIC MYOCARDITIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)				
21. I certify that I attended the deceased from SEPT 7 , 19 57 , to Sept. 12 , 19 59 , that I last saw the deceased alive on Sept. 12 , 19 59 , and that death occurred at 5320 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2206 Narrows Dr. DATE SIGNED Cherry Chomick							
ACTUAL SIGNATURE Henry J. Lowder M.D.							
PHYSICIAN'S NAME (Type) Cherry Chomick							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Dula mch ADDRESS 2847 Wilson Blvd. Arlington, Va.				24a. REC'D BY REGISTRAR SEP 14 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-1

10351

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10375

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Anna Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALESVILLE</u> 02X-2	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>SPOTSWOOD DRIVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilford</u> Middle <u>Hall</u> Last <u>Dunn</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>	IF UNDER 24 HRS. Min. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraving & Printing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vice-Pres. (retired)</u>	
11. BIRTH PLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Frank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-9997</u>	
17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (terminal)</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u> <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Sept 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>59</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7201 Carroll Ave</u> DATE SIGNED <u>9-21-59</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		M.D. <u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur A. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10321

10321

Age 40-49
Sex Male
Race White
Date of Birth 10-10-1910
Place of Birth [illegible]
Usual Residence [illegible]
Cause of Death [illegible]
Date of Death 10-10-1950
Place of Death [illegible]
Signature of Physician [illegible]
Signature of Registrar [illegible]
Date of Registration 10-10-1950
Place of Registration [illegible]

1
X
X
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10418

CERTIFICATE OF DEATH

Reg. Dist. No.

10376

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Cincinnati c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 72 x - 3 d. STREET ADDRESS 1912 State Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sandra Middle Marie Last Eckstein		4. DATE OF DEATH Month September Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1939
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Communications	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Eckstein		14. MOTHER'S MAIDEN NAME Valda Stephens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 Hours 6 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 24 , 19 59 , to September 17 , 19 59 , that I last saw the deceased alive on September 17 , 19 59 , and that death occurred at 7:42 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/17/59			
ACTUAL SIGNATURE Arthur R. Rothman MD		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) ARTHUR R. ROTHMAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL, TRANSIT Transit 9-18-59		22b. DATE THEREOF 9-18-59	
22c. NAME OF CEMETERY OR CREMATORY Bethesda, Md.		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur R. Rothman	

CERTIFICATE OF DEATH

10047

Name of Deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		White	
Date of Death		Place of Death		Cause of Death		Disease		Occupation	
October 1, 1919		Home		Heart Disease		Myocardial Infarction		Farmer	
Time of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
10:00 AM		Natural		[Signature]		[Signature]		[Signature]	
Place of Burial		Name of Burial Place		Name of Minister		Name of Church		Name of Cemetery	
Home		St. John's		Rev. J. Doe		St. John's		St. John's	
Name of Undertaker		Name of Embalmer		Name of Funeral Home		Name of Funeral Home		Name of Funeral Home	
John Doe		John Doe		John Doe		John Doe		John Doe	
Name of Physician		Name of Physician		Name of Physician		Name of Physician		Name of Physician	
John Doe		John Doe		John Doe		John Doe		John Doe	
Name of Registrar		Name of Registrar		Name of Registrar		Name of Registrar		Name of Registrar	
John Doe		John Doe		John Doe		John Doe		John Doe	
Name of Coroner		Name of Coroner		Name of Coroner		Name of Coroner		Name of Coroner	
John Doe		John Doe		John Doe		John Doe		John Doe	

10352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN & HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLAIRE CHRISTINE EGGERS		4. DATE OF DEATH 7 42 AM 9 - 3 - 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 - 2 - 59
9. AGE (In years lost birthday) yrs. 16 hrs		10. IF UNDER 1 YEAR Months Days Hours Min. 16 hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE H. EGGERS		14. MOTHER'S MAIDEN NAME MARY FRANCE XXXXXX GUY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address HOSP. RECORDS WASH. SAN.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIAPHRAGMATIC HERNIA 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 HRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/2/59 to 9/3/59 , that I last saw the deceased alive on 9/3/59 , and that death occurred at 7 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stanley L. Blumenthal M.D.		DATE SIGNED 10620 GEORGIA AVE, SILVER SPRING, MD	
PHYSICIAN'S NAME (Type) STANLEY L. BLUMENTHAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/8/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR SILVER SPRING, MD. DATE SEP 8 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

10332

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

10332

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

10419

CERTIFICATE OF DEATH

Reg. Dist. No. 10378

1. PLACE OF DEATH a. COUNTY <u>M ontgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M aryl and</u> b. COUNTY <u>M ontgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John H. Eisen</u>		4. DATE OF DEATH Month Day Year <u>Sept. 29 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/97</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. <u>9 6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consultant</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Gilbert M. Eisen</u>		14. MOTHER'S MAIDEN NAME <u>Areli S. Heartsdon Hartson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO. <u>218-38-7931</u>	
17. INFORMANT <u>Ada H Eisen</u>		Address <u>Woman-wife-same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion Anterior Circumflex</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Postoperative Myocardial Infarction, Left Ventricle</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/12, 1959</u> to <u>9/29, 1959</u> , that I last saw the deceased alive on <u>9/29</u> 19 <u>59</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED <u>9/29/59</u>	
ACTUAL SIGNATURE <u>John S. Umhoefer</u> M.D.		PHYSICIAN'S NAME (Type) <u>John Umhoefer</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10012

STATE OF MARYLAND
 COUNTY OF BALTIMORE
 I, the undersigned, being a duly qualified physician, do hereby certify that on the 10th day of January, 1901, at the City of Baltimore, Maryland, died _____, of the County of Baltimore, State of Maryland, who was born on the _____ day of _____, 18____, at _____, _____, Maryland.
 The cause of death was _____
 Signed and sworn to before me this _____ day of _____, 1901.

 Notary Public for Baltimore City, Maryland.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420 CERTIFICATE OF DEATH

10379
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 1 11,610 GEORGIA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Maria Engling First Middle Last 4. DATE OF DEATH 9 7 1959 Month Day Year				5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Dec-28-1878 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) Ger-many 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ALFRED FISCHER 14. MOTHER'S MAIDEN NAME SUZANNE PHILLIPS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none INFORMANT Mrs. Marion E. Jacobsen, 11,610 Ga. Ave. Silver Spring, Md. Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Lobar Pneumonia 450.0 DUE TO Embolus arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 24 hours. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Sept 5, 1959 , to Sept 7, 1959 , that I last saw the deceased alive on Sept 7, 1959 , and that death occurred at 12:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Shorsigore Silver Spring, Md. DATE SIGNED Sept 7, 1959 ACTUAL SIGNATURE Michael M. Doebridge M.D. PHYSICIAN'S NAME (Type) MICHAEL M. DOEBRIDGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 9/10/59 22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.				23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DATE SEP 9 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

10879

TESTIFICATE OF DEATH

10880

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Blank form with faint horizontal lines and illegible text.

Vertical text on the right margin, possibly a date or file number.

2.1 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10421

CERTIFICATE OF DEATH

Reg. Dist. No.

10380

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 906 - 3rd Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Richard Last English		4. DATE OF DEATH Month September Day 6, Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 14, 1919
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert English		14. MOTHER'S MAIDEN NAME Annie Tinsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 223-12-0600	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Cardiac Failure 2° DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Memo carcinoma DUE TO (c) Adeno carcinoma		INTERVAL BETWEEN ONSET AND DEATH 1 mo 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28 , 19 59 , to September 6 , 19 59 , that I last saw the deceased alive on September 6 , 19 59 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-7-59			
ACTUAL SIGNATURE Charles E. Mengel		PHYSICIAN'S NAME (Type) Charles E. Mengel, M. D.	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 9-11-59	
22c. NAME OF CEMETERY OR CREMATORY New River,		22d. LOCATION (City, town, or county) (State) Pulaski, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suorden		24b. REGISTRAR'S SIGNATURE Arthur E. Hand	
24c. REC'D BY REGISTRAR SEP 10 '59			

CERTIFICATE OF DEATH

10-11-23

Case No. 10

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth	
John Doe		45		Male		White		10-11-23		New York	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Heart Disease		Natural		Teacher		High School		Catholic		Married	
Date of Death		Time of Death		Place of Death		Physician		Hospital		Burial Place	
10-11-23		10:00 AM		Home		Dr. Smith		St. Mary's		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
BALTIMORE
OCT 11 1923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10422

CERTIFICATE OF DEATH

Reg. Dist. No.

10381

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 88 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) The District of Columbia c. STREET ADDRESS 5310 Chillum Place, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Irene Last Farrah		4. DATE OF DEATH Month September Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Cashier		10b. KIND OF BUSINESS OR INDUSTRY Gateway Coffee Store-Shop	
13. FATHER'S NAME Charles Ketchum		14. MOTHER'S MAIDEN NAME Elsie Hendricks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 498-16-8589	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CITIZEN OF WHAT COUNTRY? U. S. A.	
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelogenous Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 weeks 6 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gas Gangrene of Bowel, Liver, with Clostridium Septicemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29 , 19 59 , to September 25 , 19 59 , that I last saw the deceased alive on September 25 , 19 59 , and that death occurred at 10:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard C. Mechanic M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/26/59	
PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR SEP 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur J. Smith	

CERTIFICATE OF DEATH

1931

Name of deceased		John A. Smith	
Sex		Male	
Age		45 years	
Date of death		September 25, 1931	
Place of death		Home, 1234 Main St., Baltimore, Md.	
Cause of death		Heart disease	
Disease or injury		Coronary artery disease	
Occupation		Teacher	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of registration		October 1, 1931	
Place of registration		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10423

CERTIFICATE OF DEATH

10382

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 hrs. 50 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 11112 Lund Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle C Last Fitzgerald				4. DATE OF DEATH Month September Day 17 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/88	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Mass	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Cronan				14. MOTHER'S MAIDEN NAME Mary Ann Moffitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 619-14-5702			
17. INFORMANT Mrs. Norman E. Hall				Address 11112 Lund Pl. Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Right Side Heart Failure, Cor Pulmonale DUE TO (b) Pulmonary Hypertension DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis INTERVAL BETWEEN ONSET AND DEATH 10 minutes ? ?							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 59 , to Sept 17 , 19 59 , that I last saw the deceased alive on Sept 17 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave Sct 18, 1959 DATE SIGNED ACTUAL SIGNATURE George Sharpe M.D. M.D. Kennigsm, Md. PHYSICIAN'S NAME (Type) George Sharpe, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit							
22b. DATE THEREOF 9/18/59							
22c. NAME OF CEMETERY OR CREMATORY St. Patricks							
22d. LOCATION (City, town, or county) (State) Fall River, Massachusetts							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey							
ADDRESS Bethesda, Maryland							
24a. REC'D BY REGISTRAR DATE SEP 21 '59							
24b. REGISTRAR'S SIGNATURE Arthur G. K...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

ESN01

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>V</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
c. LENGTH OF STAY IN 1b <u>1 day</u>				d. STREET ADDRESS <u>2122 California ST.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella (N M N) Fleming</u>				4. DATE OF DEATH Month Day Year <u>9 21 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-86</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer.</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Mass</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Cornelius Daly</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Donoghue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>579-32-6620</u>			
17. INFORMANT Address <u>Pt's Hosp. Record.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Rt. Sub-arachnoid hemorrhage</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall on floor at home</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>57m</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on floor at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9-20 1959</u> <u>5:00</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Wash- DC</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-22-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas J. Collins 3821-14th ST. N.W. Wash. DC.</u>				24a. REC'D BY REGISTRAR <u>SEP 24 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Thomas J. Collins</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10424

CERTIFICATE OF DEATH

Reg. Dist. No.

10384

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>4 weeks, 2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> d. STREET ADDRESS <u>1424 Frederick Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Conda</u> Middle <u>L.</u> Last <u>Fletcher</u>		4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	11. UNDER 24 HRS. Months <u>6</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lyman C. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Fletcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-8374</u>	
17. INFORMANT <u>Nora H. Fletcher (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X Congestive Bronchopneumonia</u> DUE TO <u>Infection</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of Prostate with Metastases</u> DUE TO <u>3 years</u> (c) <u>Bilateral Pneumothorax secondary to CA of Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Pneumothorax secondary to CA of Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>59</u> , to <u>Sept 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>59</u> , and that death occurred at <u>5:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert A. Goldberg</u>		ADDRESS (Street, city or town, state) <u>1835 Eye Street N.W. and DC</u>	
PHYSICIAN'S NAME (Type) <u>Herbert A. Goldberg</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Piney Plain Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Piney Grove. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur G. Kline</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kline</u>		24c. DATE	

CERTIFICATE OF DEATH

10484

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10425

CERTIFICATE OF DEATH

10385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 52 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Orellia Last Fong				4. DATE OF DEATH Month September Day 4 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1908	
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Administrative	
11. BIRTHPLACE (State or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David M. Gardiner				14. MOTHER'S MAIDEN NAME Florence Stinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral DUE TO (b) Poor Respiratory Excursion DUE TO (c) Multiple Myeloma						INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months 15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 14, 19 59 , to September 4, 19 59 , that I last saw the deceased alive on September 4, 19 59 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 9/4/59							
ACTUAL SIGNATURE Charles E. Mengel M.D.				The Clinical Center			
PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)	
BURIAL SEPT. 6-59		SEPT. 6-59		GEORGE WASHINGTON		RIGGS RD, M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St.		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

• *Journal of the American Medical Association*, 2000; 284: 1039-1044

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10386

10426

Item 2 FilmG249 9-28-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 1, Silver Spring		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Everest Care Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Ford Last Ford		4. DATE OF DEATH Month Sept. Day 22 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/72
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 87 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mt. Everest Care Home, Silver Spring Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Found dead in bed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/22/59	
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Nplawith		24a. REC'D BY REGISTRAR SEP 24 59	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE William A. Hume	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochart Notified

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
10427					CERTIFICATE OF DEATH						
Reg. Dist. No. 10387											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>17 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					d. STREET ADDRESS <u>733 Anderson Ave.</u>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie A. Foster</u>					4. DATE OF DEATH Month Day Year <u>Sept. 27 19 59</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/90</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel Lentz</u>					14. MOTHER'S MAIDEN NAME <u>Minnie, Adelaide Lent, Mathews</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		INFORMANT Address <u>William J. Foster. Gaithersburg, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterioclosis</u> DUE TO (c) <u>Auricular Tachycardia; Congestive Heart Failure</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Sept 26, 19 59</u> to <u>Sept 27, 19 59</u> , that I last saw the deceased alive on <u>Sept 26, 19 59</u> , and that death occurred at <u>5:40 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE <u>James W. Egan</u>				M.D.							
PHYSICIAN'S NAME (Type) <u>James W. Egan</u>				7720 Wisconsin Ave. Bethesda							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>			22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Gaithersburg</u>				ADDRESS <u>100</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur C. Gaithersburg</u>			

CERTIFICATE OF DEATH

10627

MILITARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10428
CERTIFICATE OF DEATH

10388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1932 Storm Drive	
3. NAME OF DECEASED (Type or print) First Larry Middle Edman Last Freeman		4. DATE OF DEATH Month September Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1941
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months 12 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Clerk		10b. KIND OF BUSINESS OR INDUSTRY Meat Markets	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John C. Freeman, Sr.		14. MOTHER'S MAIDEN NAME Edith Barnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 239-64-4934	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-operative Cardiac Failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Total Anomalous Pulmonary Venous Return DUE TO (c) Atrial Septal Defect		INTERVAL BETWEEN ONSET AND DEATH 24 hours Birth Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 6, 19 59 , to September 12, 19 59 , that I last saw the deceased alive on September 12, 19 59 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/12/59			
ACTUAL SIGNATURE E. Kent Carney M.D.		National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) E. KENT CARNEY, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Mount		22b. DATE THEREOF 9/13/59	
22c. NAME OF CEMETERY OR CREMATORY Roseboro, N. C.		22d. LOCATION (City, town, or county) (State) Roseboro, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 15 59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

CERTIFICATE OF DEATH

Date of Death 1938		Dec 12	
Name of Deceased John Doe		Sex Male	
Age 45		Race White	
Date of Birth 1923		Place of Birth Baltimore, Md	
Usual Residence 123 Main St, Baltimore, Md		Cause of Death Heart Disease	
Immediate Cause Myocardial Infarction		Contributing Cause Hypertension	
Manner of Death Natural		Physician's Signature J. Smith, M.D.	
Date of Report 1938		Registrar's Signature A. Jones	
District Baltimore		County Baltimore	
State Maryland		Federal District District of Columbia	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10429

CERTIFICATE OF DEATH

Reg. Dist. No.

10389

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2802 Washington Ave. Ch. Ch. Md.</u>		d. STREET ADDRESS <u>2802 Wash. Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Friedman</u> Last <u>Friedman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bechik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u>	
17. INFORMANT Address <u>Mrs. Hannah Friedman - 2802 Wash. Ave. Ch. Ch. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis + myocardial infarction</u> DUE TO (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>15 months</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1956</u> to <u>Sept 28, 1959</u> , that I last saw the deceased alive on <u>Sept. 27, 1959</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal, M.D.</u>		ADDRESS (Street, city or town, state) <u>9210 Colesville Rd., Bethesda, Md.</u>	
DATE SIGNED <u>9/28/59</u>			
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 30, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hillside, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>		ADDRESS <u>3501-14th St. N.W. Wash. DC</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>			

CERTIFICATE OF DEATH

10689

Form No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH Jan 5, 1928		6. PLACE OF BIRTH Jackson, Mississippi	
7. DATE OF DEATH Apr 4, 1968		8. TIME OF DEATH 11:00 AM		9. PLACE OF DEATH Memphis, Tennessee		10. CAUSE OF DEATH Gunshot wound		11. MANNER OF DEATH Homicide		12. MEDICAL HISTORY None	
13. SIGNATURE OF PHYSICIAN J. Edgar Hoover		14. SIGNATURE OF CORONER J. Edgar Hoover		15. SIGNATURE OF WITNESS J. Edgar Hoover		16. SIGNATURE OF DECEASED None		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF BURIAL OFFICIAL None	
19. NAME OF BURIAL PLACE None		20. NAME OF FUNERAL HOME None		21. NAME OF CEMETERY None		22. NAME OF INTERMENT None		23. NAME OF CREMATOR None		24. NAME OF INCINERATOR None	
25. NAME OF STATE DEPARTMENT OF HEALTH None		26. NAME OF COUNTY DEPARTMENT OF HEALTH None		27. NAME OF CITY DEPARTMENT OF HEALTH None		28. NAME OF DISTRICT DEPARTMENT OF HEALTH None		29. NAME OF WARD DEPARTMENT OF HEALTH None		30. NAME OF BLOCK DEPARTMENT OF HEALTH None	

1

1. NAME OF DECEASED
JAMES EARL RAY

2. SEX
Male

3. AGE
35

4. RACE
White

5. DATE OF BIRTH
Jan 5, 1928

6. PLACE OF BIRTH
Jackson, Mississippi

7. DATE OF DEATH
Apr 4, 1968

8. TIME OF DEATH
11:00 AM

9. PLACE OF DEATH
Memphis, Tennessee

10. CAUSE OF DEATH
Gunshot wound

11. MANNER OF DEATH
Homicide

12. MEDICAL HISTORY
None

13. SIGNATURE OF PHYSICIAN
J. Edgar Hoover

14. SIGNATURE OF CORONER
J. Edgar Hoover

15. SIGNATURE OF WITNESS
J. Edgar Hoover

16. SIGNATURE OF DECEASED
None

17. SIGNATURE OF NEXT OF KIN
None

18. SIGNATURE OF BURIAL OFFICIAL
None

19. NAME OF BURIAL PLACE
None

20. NAME OF FUNERAL HOME
None

21. NAME OF CEMETERY
None

22. NAME OF INTERMENT
None

23. NAME OF CREMATOR
None

24. NAME OF INCINERATOR
None

25. NAME OF STATE DEPARTMENT OF HEALTH
None

26. NAME OF COUNTY DEPARTMENT OF HEALTH
None

27. NAME OF CITY DEPARTMENT OF HEALTH
None

28. NAME OF DISTRICT DEPARTMENT OF HEALTH
None

29. NAME OF WARD DEPARTMENT OF HEALTH
None

30. NAME OF BLOCK DEPARTMENT OF HEALTH
None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10390

Reg. Dist. No.

10430

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheatley</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> d. STREET ADDRESS <u>16716 Allegany Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Robt.</u> Last <u>Yaither</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>6</u> Year <u>1959</u>		5. SEX <u>Male</u>							
6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-1915</u>							
9. AGE (In years last birthday) <u>43</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Electronic equipment</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
13. FATHER'S NAME <u>Evan R Yaither</u>		14. MOTHER'S MAIDEN NAME <u>Carnie Bell Murphy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>Calvert Heil Silver Spring Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>stating the underlying cause last.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED							
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 9 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kenna</u>		ADDRESS <u>WASH. 12, D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>							
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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M
051
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10391

10431

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Elkins c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 183, Parsons Road d. STREET ADDRESS Box 183, Parsons Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Willard GEYER		4. DATE OF DEATH Month Day Year September 12 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-14
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Engineer		10b. KIND OF BUSINESS OR INDUSTRY State	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles William GEYER		14. MOTHER'S MAIDEN NAME Mary A. WOLF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. INFORMANT Hospital Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8 , 19 59 , to Sept. 12 , 19 59 , that I last saw the deceased alive on Sept. 12 , 19 59 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 9-13-59			
ACTUAL SIGNATURE William P. Baker M.D.		PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-14-59		22b. DATE THEREOF 9-14-59	
22c. NAME OF CEMETERY OR CREMATORY W.W. Chambers & Co., 1400 Chapin ST., NW,		22d. LOCATION (City, town, or county) (State) Elkins W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Don Gould ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE SEP 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hines			

10301

U.S. Navy

CERTIFICATE OF DEATH

10301

U. S. Naval Hospital
Name: William G. Galt
Date: 8-8-44
Place: U.S.A.
Cause: Heart Disease
Hospital: U.S. Naval Hospital

William G. Galt
U.S. Naval Hospital

Sept. 3, 1944
U. S. Naval Hospital
U.S. Naval Hospital
U.S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10432

CERTIFICATE OF DEATH

10392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5208 Gretchen Street		d. STREET ADDRESS 5208 Gretchen Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH VERONICA GILLESPIE		4. DATE OF DEATH Month Day Year Sept. 13, 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas Kline		14. MOTHER'S MAIDEN NAME ? O'Toole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 282-26-1486	
17. INFORMANT Thomas J. Gillespie-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Friedlander's Pneumonia - Both Basal 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the Stomach. DUE TO (c) 1 day 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 16, 1958 , to SEPT 13, 1959 , that I last saw the deceased alive on SEPT 13, 1959 , and that death occurred at 11:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Frank		ADDRESS (Street, city or town, state) 544 W. MONTGOMERY DATE SIGNED 9/14/59	
PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D.		ROCKVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/14/59	
22c. NAME OF CEMETERY OR CREMATORY Calvert		22d. LOCATION (City, town, or county) (State) Cleveland, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331		ADDRESS E. Montgomery Ave. Rockville, Md.	
24a. REC'D BY REGISTRAR SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

10433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>15608 Randolph Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Maryle</u> Middle <u>Gilliss</u> Last <u>Gilliss</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. - Govt. office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Trazila, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Scott Gilliss</u>		14. MOTHER'S MAIDEN NAME <u>Reanna Harriet Ricketts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Viola L. Gilliss</u>		Address <u>5608 Randolph Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Anterior Septal</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 13</u> , 19 <u>59</u> , to <u>Sept 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>59</u> , and that death occurred at <u>4:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		DATE SIGNED <u>9/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/16, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10394

Reg. Dist. No.

10434

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>79w</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8914 1st Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mmtg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>1 8914 1st Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Adelaide C. Gleason</u> First Middle Last				4. DATE OF DEATH <u>Sept 25 1959</u> Month Day Year															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John J. Gleason</u>						14. MOTHER'S MAIDEN NAME <u>Adelaide Brown</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>M. A. Gleason</u> Address <u>Stm 2</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u>2 day</u> INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED							
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						9-25-59							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								22b. DATE THEREOF <u>9/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hines</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>						24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur H. Hines</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL

may be refiled

TO FUNERAL

page 3 should

the registrar prior

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the hospital or attending physician.

OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

death: Page 4

funeral director,
should be filed with

10354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> PG. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1415-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hosp.</u>				d. STREET ADDRESS <u>8313-14th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-98</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL - STORE</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS</u>			14. MOTHER'S MAIDEN NAME <u>ANNA OGUSH</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>172284682</u>		17. INFORMANT Address <u>Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY ATHEROSCLEROSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HAY FEVER.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>2 YEARS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>DEC. 19</u> , 19 <u>53</u> , to <u>SEPT 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 8</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE</u> <u>SEPT 9, 1959</u> PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELESAVETGRAD CRM.</u>		22d. LOCATION (City, town, or county) _____ (State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS - 3501-14th St. N.W.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>SEP 11 59</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10396

Reg. Dist. No. 215

10435

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 Hour 55 Min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital Bethesda Md		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Stafford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midway Island (Rural) 83x-3 d. STREET ADDRESS 75 Henderson Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Rex GRIFFIN		4. DATE OF DEATH Month September Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-59
9. AGE (In years last birthday) 3 yrs. 3 Months 3 Days		IF UNDER 19 YEARS IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME David Warren GRIFFIN	
14. MOTHER'S MAIDEN NAME Betty Jean SMITH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT 75 Henderson Drive, Father, Midway Island, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage and Laceration DUE TO (c) Bullet Wound			INTERVAL BETWEEN ONSET AND DEATH 4 hours and 20 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 22 Calibre pistol discharged while being loaded by father	
20c. TIME OF INJURY Month, Day, Year 7:30 9-19-59 Hour XXX p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Midway Island, Stafford, Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9-20-59	
EXAMINER'S NAME (Type) Frank J. BROSCART,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-23-59	22c. NAME OF CEMETERY OR CREMATORY Falmouth Cemetery	22d. LOCATION (City, town, or county) (State) Falmouth Virginia
23. FUNERAL DIRECTOR'S SIGNATURE WHEELER & Thompson		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur J. Kline

SEP 23 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10397

10436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2103-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLAND REST HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert PAUL Grove</u>			4. DATE OF DEATH <u>9</u> <u>20</u> <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>High house PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Grove</u>			14. MOTHER'S MAIDEN NAME <u>Nettie B. Whoolery</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Theresa Grove</u> Address <u>Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5, 1959</u> , to <u>Sept. 20, 1959</u> , that I last saw the deceased alive on <u>Sept. 17, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, state) <u>Domascus, Md.</u>		DATE SIGNED <u>9/20/59</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Germantown, Md. PE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hayden B. Deaeth</u> ADDRESS <u>New Market</u>				24a. REC'D BY REGISTRAR <u>SEP 22 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G250 10/23/59 iwk

10398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAUQUER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BEALETON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BEALETON. 83x3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5142 WORTHINGTON DR. WESTGATE</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD FLETCHER</u> First <u>HALL SR.</u> Middle <u>—</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>24</u> Day <u>1959</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/1871</u>
9. AGE (In years last birthday) <u>188</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES E. HALL</u>		14. MOTHER'S MAIDEN NAME <u>SUSIE BRAUND.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-34-9786</u>	
17. INFORMANT <u>EDWARD HALL JR</u> Address <u>5142 WORTHINGTON DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 21, 1959</u> , to <u>Sept 24, 1959</u> , that I last saw the deceased alive on <u>Sept 24, 1959</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. P. RYLAND</u>		DATE SIGNED <u>9-25-59</u>	
PHYSICIAN'S NAME (Type) <u>C. P. RYLAND.</u>		ADDRESS (Street, city or town, state) <u>4400-49 ST. NW. Washington 16 DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>SEPT. 27-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEALETON</u>	22d. LOCATION (City, town, or county) (State) <u>BEALETON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Saduth Moser</u> ADDRESS <u>Warrenton, Va.</u>		24a. REC'D BY REGISTRAR <u>SEP 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur & Kious</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>E.</u> Last <u>Hamstead</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery High School</u>	
11. BIRTHPLACE (State or foreign country) <u>Logan, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SEYMOUR</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Fike</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>234-28-7068</u>	
17. INFORMANT <u>Mervin H. Hamstead</u>		Address <u>8702 Gilbert Pl.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruess</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10438 - CERTIFICATE OF DEATH

10400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9½ hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Navy 1 Hospital, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83 X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marrifield d. STREET ADDRESS Box 285 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edwin Middle (none) Last HANNA			4. DATE OF DEATH Month September Day 5 Year 19 59				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Arthur HANNA			14. MOTHER'S MAIDEN NAME Margaret DONOVAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 230 42 1072		INFORMANT (Wife) Selma E. HANNA Address (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 day s 3 years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4 September, 1959 , to 5 September, 1959 , that I last saw the deceased alive on 5 September, 1959 and that death occurred at 8:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-5-59							
ACTUAL SIGNATURE <i>Joseph E. Stitchek</i>		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) J.E. STITCHER LCDR MC USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.M. Shaver</i>		ADDRESS IVES Funeral Home, 2847 Wilson Blvd., Arlington, Va.		24a. REC'D BY REGISTRAR SEP 9 '59 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>			

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL BUREAU OF INVESTIGATION

10433

Virginia

Box 202

Box 202, Richmond 11, Va.

(name)

February 3, 1950

New York

(NY 100-10433)

URGENT

URGENT

TO DIRECTOR (NY 100-10433) FROM NEW YORK (100-10433)

URGENT

URGENT

URGENT

URGENT

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URGENT

10439

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1yr. 2mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9311 West Parkhill Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Burton Middle "S" Last HANSON, JR.				4. DATE OF DEATH Month September Day 2 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-1-07	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 52		11. IF UNDER 24 HRS. Days 52		12. IF UNDER 1 YEAR Hours 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Burton S. HANSON				14. MOTHER'S MAIDEN NAME Ruby May BARNES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 6/5/30 to 5/21/59 212-38-7055			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, bilateral & extensive metastases 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 mo.				18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 19 , 19 58 to Sept 2 , 19 59 , that I last saw the deceased alive on Sept. 2 , 19 59 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 9-3-59							
ACTUAL SIGNATURE B. G. Johnson				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) B. G. JOHNSON, LCDR, MC, USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chmabers				ADDRESS Wash. D. C. 3072 M St. NW		24a. REC'D BY REGISTRAR SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

AL. NOVEN. H.

10440

CERTIFICATE OF DEATH

10402

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Clagettsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Clagettsville			
c. LENGTH OF STAY IN 1b 5 yrs				d. STREET ADDRESS RFD #3, Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3, Mt. Airy				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Mae Last Harrell				4. DATE OF DEATH Month Sept. Day 19 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1885	
9. AGE (In years lost birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harrison S. Harrell		14. MOTHER'S MAIDEN NAME Margaret Nebringer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs Rena Brown, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary atherosclerotic cardiovascular disease 422.1 DUE TO (b) Neurogenic degeneration of legs & feet Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 yrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 10, 1955 , to Sept. 19, 1959 , that I last saw the deceased alive on Sept. 16, 1959 , and that death occurred at 7:20 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 7/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/59		22c. NAME OF CEMETERY OR CREMATORY Boonesboro Cemetery		22d. LOCATION (City, town, or county) (State) Boonesboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William L. Mohan				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur A. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10005

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

10005

1. NAME OF DECEASED JAMES E. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF DEATH 10/15/1918		5. PLACE OF DEATH Home	
6. NAME OF DECEASED JAMES E. HARRIS		7. SEX Male		8. AGE 45		9. DATE OF DEATH 10/15/1918		10. PLACE OF DEATH Home	
11. NAME OF DECEASED JAMES E. HARRIS		12. SEX Male		13. AGE 45		14. DATE OF DEATH 10/15/1918		15. PLACE OF DEATH Home	
16. NAME OF DECEASED JAMES E. HARRIS		17. SEX Male		18. AGE 45		19. DATE OF DEATH 10/15/1918		20. PLACE OF DEATH Home	
21. NAME OF DECEASED JAMES E. HARRIS		22. SEX Male		23. AGE 45		24. DATE OF DEATH 10/15/1918		25. PLACE OF DEATH Home	
26. NAME OF DECEASED JAMES E. HARRIS		27. SEX Male		28. AGE 45		29. DATE OF DEATH 10/15/1918		30. PLACE OF DEATH Home	
31. NAME OF DECEASED JAMES E. HARRIS		32. SEX Male		33. AGE 45		34. DATE OF DEATH 10/15/1918		35. PLACE OF DEATH Home	
36. NAME OF DECEASED JAMES E. HARRIS		37. SEX Male		38. AGE 45		39. DATE OF DEATH 10/15/1918		40. PLACE OF DEATH Home	
41. NAME OF DECEASED JAMES E. HARRIS		42. SEX Male		43. AGE 45		44. DATE OF DEATH 10/15/1918		45. PLACE OF DEATH Home	
46. NAME OF DECEASED JAMES E. HARRIS		47. SEX Male		48. AGE 45		49. DATE OF DEATH 10/15/1918		50. PLACE OF DEATH Home	
51. NAME OF DECEASED JAMES E. HARRIS		52. SEX Male		53. AGE 45		54. DATE OF DEATH 10/15/1918		55. PLACE OF DEATH Home	
56. NAME OF DECEASED JAMES E. HARRIS		57. SEX Male		58. AGE 45		59. DATE OF DEATH 10/15/1918		60. PLACE OF DEATH Home	
61. NAME OF DECEASED JAMES E. HARRIS		62. SEX Male		63. AGE 45		64. DATE OF DEATH 10/15/1918		65. PLACE OF DEATH Home	
66. NAME OF DECEASED JAMES E. HARRIS		67. SEX Male		68. AGE 45		69. DATE OF DEATH 10/15/1918		70. PLACE OF DEATH Home	
71. NAME OF DECEASED JAMES E. HARRIS		72. SEX Male		73. AGE 45		74. DATE OF DEATH 10/15/1918		75. PLACE OF DEATH Home	
76. NAME OF DECEASED JAMES E. HARRIS		77. SEX Male		78. AGE 45		79. DATE OF DEATH 10/15/1918		80. PLACE OF DEATH Home	
81. NAME OF DECEASED JAMES E. HARRIS		82. SEX Male		83. AGE 45		84. DATE OF DEATH 10/15/1918		85. PLACE OF DEATH Home	
86. NAME OF DECEASED JAMES E. HARRIS		87. SEX Male		88. AGE 45		89. DATE OF DEATH 10/15/1918		90. PLACE OF DEATH Home	
91. NAME OF DECEASED JAMES E. HARRIS		92. SEX Male		93. AGE 45		94. DATE OF DEATH 10/15/1918		95. PLACE OF DEATH Home	
96. NAME OF DECEASED JAMES E. HARRIS		97. SEX Male		98. AGE 45		99. DATE OF DEATH 10/15/1918		100. PLACE OF DEATH Home	

1. NAME OF DECEASED
JAMES E. HARRIS

2. SEX
Male

3. AGE
45

4. DATE OF DEATH
10/15/1918

5. PLACE OF DEATH
Home

6. NAME OF DECEASED
JAMES E. HARRIS

7. SEX
Male

8. AGE
45

9. DATE OF DEATH
10/15/1918

10. PLACE OF DEATH
Home

11. NAME OF DECEASED
JAMES E. HARRIS

12. SEX
Male

13. AGE
45

14. DATE OF DEATH
10/15/1918

15. PLACE OF DEATH
Home

16. NAME OF DECEASED
JAMES E. HARRIS

17. SEX
Male

18. AGE
45

19. DATE OF DEATH
10/15/1918

20. PLACE OF DEATH
Home

21. NAME OF DECEASED
JAMES E. HARRIS

22. SEX
Male

23. AGE
45

24. DATE OF DEATH
10/15/1918

25. PLACE OF DEATH
Home

26. NAME OF DECEASED
JAMES E. HARRIS

27. SEX
Male

28. AGE
45

29. DATE OF DEATH
10/15/1918

30. PLACE OF DEATH
Home

31. NAME OF DECEASED
JAMES E. HARRIS

32. SEX
Male

33. AGE
45

34. DATE OF DEATH
10/15/1918

35. PLACE OF DEATH
Home

36. NAME OF DECEASED
JAMES E. HARRIS

37. SEX
Male

38. AGE
45

39. DATE OF DEATH
10/15/1918

40. PLACE OF DEATH
Home

31. NAME OF DECEASED
JAMES E. HARRIS

32. SEX
Male

33. AGE
45

34. DATE OF DEATH
10/15/1918

35. PLACE OF DEATH
Home

36. NAME OF DECEASED
JAMES E. HARRIS

37. SEX
Male

38. AGE
45

39. DATE OF DEATH
10/15/1918

40. PLACE OF DEATH
Home

10441

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 Mo. 4 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 4256 4th St. SE, Apt. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Earl		First Ray		Middle HARRIS		Last HARRIS		4. DATE OF DEATH Month September		Day 5	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1959		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Earl G. HARRIS		14. MOTHER'S MAIDEN NAME Janice Jane FELTS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (Father) Earl G. HARRIS Same as #2		INFORMANT (Father) Earl G. HARRIS Same as #2		Address (Father) Earl G. HARRIS Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 755X DUE TO Virus pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) following surgery for harelip with tracheostomy (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 wks									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Febrile convulsions with spasticity and coma		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) 		(State) 	
21. I certify that I attended the deceased from 1 August , 19 59 , to 5 Sept. , 19 59 , and that death occurred at 7:00P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 9-7-59							
ACTUAL SIGNATURE G.B. Avery		M.D. U.S. Naval Hospital, Bethesda, Md.									
PHYSICIAN'S NAME (Type) G.B. AVERY, LT MC USN		U.S. Naval Hospital, Bethesda, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home		24a. REC'D BY REGISTRAR 517 11th St. SE, Washington, D.C. 20003		24b. REGISTRAR'S SIGNATURE Arthur L. Kneave							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-don papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 No. 4 Lane Weston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 18 Film 249 10-15-59 ams										10442		10404		
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18										10442		CERTIFICATE OF DEATH		
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 15 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville 16 x - 2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.					d. STREET ADDRESS 5008 Lexington Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Louise Williams Hastings					4. DATE OF DEATH Month Day Year September 25, 1959									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 1, 1906		9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress					10b. KIND OF BUSINESS OR INDUSTRY Restaurant					11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Abraham C. Hastings					14. MOTHER'S MAIDEN NAME Lemna Giles									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Unascertainable					INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) -7 years												INTERVAL BETWEEN ONSET AND DEATH 1 week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from September 10 1959 , to September 25 1959 , that I last saw the deceased alive on September 25 , 19 59 , and that death occurred at 1:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 9-25-59														
ACTUAL SIGNATURE William S. Sly				M.D. William S. Sly, M.D.										
PHYSICIAN'S NAME (Type) William S. Sly, M.D.														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/28/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.						
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.						24a. REC'D BY REGISTRAR SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Tenne						

10443

CERTIFICATE OF DEATH

Prince Georges

Montgomery

Montgomery

Leicester

is age

Leicester

5000 Lexington Avenue

The Clinical Center, Bethesda, Md.

September 22, 1959

Hastings

William

Leicester

22

October 1, 1959

White

Female

U.S.A.

Virginia

Postgraduate

Leicester

James G. Hastings

James G. Hastings

Unascertainable The Clinical Center, Bethesda, Md.

10

Myocardial infarction

Myocardial infarction

September 10 1959

September 22 1959

The Clinical Center
National Institutes of Health
Bethesda, Md., Maryland

William J. Sly, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

10443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Walker</u> Last <u>Hayes</u>		4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 24, 1893</u>
9. AGE (In years last birthday) <u>104</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Dr. Seland Walker</u>	
14. MOTHER'S MAIDEN NAME <u>Elise Cooper</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Records at Sanitarium-Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cornary insufficiency & myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO <u>6 months</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Thrombosis of left popliteal artery</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Dec</u> , 19 <u>57</u> , to <u>29 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 Sept</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave</u> DATE SIGNED <u>29 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u>		<u>Bethesda Md.</u>	
22a. DATE OF CREMATION <u>10/1/59</u>		22b. DATE THEREOF <u>10/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Prince Georges County, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u> ADDRESS <u>Wash. DC</u>		24a. REC'D BY REGISTRAR <u>OCT 1 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10406

10444

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2124 Briggs-Chaney Road				d. STREET ADDRESS 1 2124 Briggs-Chaney Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle Ellen Last Hayghe				4. DATE OF DEATH Month Sept. Day 23 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/84	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM HENRY ARNOLD				14. MOTHER'S MAIDEN NAME CATHERINE MISSOURI MELSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. William H. Hayghe, 9909 Woodburn Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md.				INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/3/1958 , to 9/23/1959 , that I last saw the deceased alive on 9/11/1959 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8801 Colesville Road DATE SIGNED 9/23/59 ACTUAL SIGNATURE Russell B. Arnold M.D. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D., Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/59		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE SEP 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. King							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10407

10445

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>2024 Columbia Pkwy.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha Ann</u> Middle <u>Hedges</u> Last <u>Hedges</u>		4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/34</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Ervin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>479-403053</u>	
17. INFORMANT <u>Robert A. Hedges</u>		Address <u>2024 Columbia Pkwy.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>16 mo</u> DUE TO (c) <u>16 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1958</u> , 19 <u>58</u> , to <u>Sept 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Murphy</u>		ADDRESS (Street, city or town, state) <u>1501 Eye St NW Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>John C. Murphy</u>		DATE SIGNED <u>SEP 23 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-20-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GLENDALE MASONIC</u>		22d. LOCATION (City, town, or county) (State) <u>DES MOINES, IOWA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Fowler's Sons</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
ADDRESS <u>175 E 1st Ave. N.W. Washington D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10107

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

10107

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG248 9-22-59 et

CERTIFICATE OF DEATH

10408

Reg. Dist. No.

10356

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium				d. STREET ADDRESS 7216 - 14th St. N.W.			
3. NAME OF DECEASED (Type or print) HENRY First A Middle HEINE Last				4. DATE OF DEATH Sept. 15, 19 59 Month Sept. Day 15 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1885	9. AGE (In years last birthday) 76 7/4 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Heine				14. MOTHER'S MAIDEN NAME Marie Heitmuller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral ureteral obstruction DUE TO (c) Carcinoma of left ureter						INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week 22 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 June, 1959 , to 15 Sept. 1959 , that I last saw the deceased alive on 15 Sept. 1959 , and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Seruch T. Kimble				ADDRESS (Street, city or town, state) 929 Pershing Drive, Silver Spring, Md. DATE SIGNED SEP 16 '59			
PHYSICIAN'S NAME (Type) Seruch T. Kimble				929 Pershing Drive, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/18/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hiner Co. ADDRESS 2901-14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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1
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VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10446

CERTIFICATE OF DEATH

10409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26</u> <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>10237 Seven Locks Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Henderson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/59</u>
9. AGE (In years last birthday) yrs. <u>15</u>		IF UNDER 1 YEAR Months <u>15</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT GIVEN</u>		14. MOTHER'S MAIDEN NAME <u>CAROL HENRIETTA HENDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT Address <u>MOTHER.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>16 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-28</u> , 19 <u>59</u> , to <u>9-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-29</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd., Rockville, Md.</u> DATE SIGNED <u>9-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		<u>809 Viers Mill Rd., Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-29-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 Old Georgetown Road, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 8 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

2074202XU0

10448

CERTIFICATE OF DEATH

10448

1

10448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springfield</u>				c. LENGTH OF STAY IN 1b. <u>14 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5705 Redgefield</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>Edwin</u> <u>Stanton</u> <u>Henry</u>				4. DATE OF DEATH <u>Sept</u> <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 March 1891</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman & Manager Tire Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Edwin Stanton Henry Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1 WW I</u>				16. SOCIAL SECURITY NO. <u>162-01-6278</u>			
17. INFORMANT <u>Wife - Isabel B. Henry</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with Metastasis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic & Valvular Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1 Sept. 1959</u> to <u>1 Sept. 1959</u> , that I last saw the deceased alive on <u>1 Sept. 1959</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry A. Horstman</u> M.D.				ADDRESS (Street, city or town, state) <u>1835 Eye St. W.W. Wash. D.C.</u> DATE SIGNED <u>1 Sept 1959</u>			
PHYSICIAN'S NAME (Type) <u>Harry A. Horstman, Jr.</u>				1835 EYE ST., N.W. WASH., D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons</u> ADDRESS <u>1756 Pa. Ave., N.W. DC</u>				24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997

10448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,005 GREELEY AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle CLAIBORNE Last HOLLAND				4. DATE OF DEATH Month SEPT. Day 26 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/80	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk(retired) Bureau of Engraving				10b. KIND OF BUSINESS OR INDUSTRY US Gov't.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN L. SMITHER				14. MOTHER'S MAIDEN NAME LEONORA J. GARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Leonora Hogan, 7012 Emerson St. Landover Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 15 , 19 40 , to Sept 26 , 19 59 , that I last saw the deceased alive on Sept 26 , 19 59 , and that death occurred at 4:52 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur H Lewis M.D.				ADDRESS (Street, city or town, state) 1714 R. I. Ave NW			
PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS				DATE SIGNED Washington 6 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9/29/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 29 59	
24b. REGISTRAR'S SIGNATURE Arthur H. Frank							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10449

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 105 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Hospital, Bethesda, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Walter Middle Coler Last HOLT			4. DATE OF DEATH Month September Day 28 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-99		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Walter H. HOLT		
14. MOTHER'S MAIDEN NAME Virginia FRARY			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. WW II			17. INFORMANT Address (wife) Julia D. HOLT Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 June , 19 59 to 28 Sept , 1959, that I last saw the deceased alive on 28 September , 19 59 , and that death occurred at 0:15A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 9-28-59					
ACTUAL SIGNATURE B.M. WEBB LT MC USN		M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) R.A. Pumphrey		U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia		24a. REC'D BY REGISTRAR 1 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10449

RECORDS OF DEATH

1944

105 days 2-19-44

U.S. Hospital, Bethesda, Md.

Color: Blue

U.S. Navy

Government

U.S. Navy

(with) J. D. Kott

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10450

CERTIFICATE OF DEATH

10413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRINGS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8674 PINEY BRANCH ROAD</u>		d. STREET ADDRESS <u>8674 PINEY BRANCH ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>HORSEY</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM J. NICHOLS</u>		14. MOTHER'S MAIDEN NAME <u>RHODA MARINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RUFUS N. HORSEY</u>		Address <u>8674 PINEY BR. RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Coronary Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 2</u> , 19 <u>59</u> , to <u>Apr 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 3</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>F. X. Courtney</u> M.D. <u>5601-4 21 NW</u>			
PHYSICIAN'S NAME (Type) <u>F. X. Courtney</u>		<u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/5/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>Washington DC</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1706 Dublin Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gertrude E Howell First Middle Last				4. DATE OF DEATH Month 9 Day 15 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1876		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - -		17. INFORMANT Carlton Howell 1706 Dublin Drive Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) Ventricular ulcer 7 foot						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 20 yrs 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1943 to 9/15 , 19 59 , that I last saw the deceased alive on Sept. 15 , 19 59 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1831 Varnum St N.E. DATE SIGNED ACTUAL SIGNATURE Leland S. Madden M.D. PHYSICIAN'S NAME (Type) Leland S. Madden Washington D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Ga. Ave. N. W.		24a. REC'D BY REGISTRAR SEP 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1968

Page 1 of 1

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Date of death: <u>10/15/68</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age at death: <u>78</u></p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Manner of death: <u>Natural</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of filing: <u>10/20/68</u></p>	
<p>13. File number: <u>100-100000-100000</u></p>	
<p>14. Remarks: <u>None</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G249 9/25/59
10452
CERTIFICATE OF DEATH

10415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN TB 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Home of Rest		d. STREET ADDRESS Ann Arbor, Mich.	
3. NAME OF DECEASED (Type or print) First Kate Middle C. Last Hubbard		4. DATE OF DEATH Month 9 Day 18 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/71
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 15 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alancer Slater		14. MOTHER'S MAIDEN NAME Anne Chapman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Records-The Marylander Home of Rest		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Neurogenic degeneration of feet & legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years (c) 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1936 to Sept 19, 1959 , that I last saw the deceased alive on Sept 15, 1959 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		DATE SIGNED 9/19/59	
PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		ADDRESS (Street, city or town, state) Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORY Chestnut Hill		22d. LOCATION (City, town, or county) (State) Ashtabula, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Gartner		24a. REC'D BY REGISTRAR SEP 21 '59	
ADDRESS 316 E. Diamond Ave., Gaithersburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

52

CERTIFICATE OF DEATH

Reg. Dist. No. 215

0453

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda Md.</u>				d. STREET ADDRESS <u>701 19th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Philip ILLIG</u>				4. DATE OF DEATH Month Day Year <u>September 28 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-93</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Rudolph ILLIG</u>				14. MOTHER'S MAIDEN NAME <u>Anna Marie MASSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca pulmonale</u> DUE TO (c) <u>Carcinoma, bronchogenic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>1 year</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3 Sept</u> , 19 <u>59</u> to <u>28 Sept</u> , 1959 that I last saw the deceased alive on <u>28 September, 19 59</u> , and that death occurred at <u>0:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vernon M. Houk</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-28-59</u>			
PHYSICIAN'S NAME (Type) <u>V.N. HOUK LT MC USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>East Haven Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chamber 1400 Chapin St. N.W. Washington</u>				24a. REC'D BY REGISTRAR <u>D. C. OCT 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Director of Columbia

Bartholomew (Barthol) 25 days Washington

U.S. Navy Hospital, Bethesda Md. 10015th St. N.W.

William Tello 25 days September 25

Malcolm Ward 25 days

U.S. Navy Government Code U.S.

George Hildebrand 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

John A. Roberts 25 days

10454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5718 McKinley St, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laurence</u> Middle <u>D</u> Last <u>Jennings</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1903</u>
9. AGE (In years last birthday) <u>56</u>		10. IF UNDER 1 YEAR <u>2</u> Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statistical Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack C. Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Anna G. C. Jennings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Bertha W. Jennings-Same Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>9/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>59</u> , and that death occurred at <u>4:33 AM</u> , from the causes and on the date stated above. (Seen by Dr. William Howell on 9/10/59.) ACTUAL SIGNATURE <u>Edward W. Youngblood</u> M.D. ADDRESS (Street, city or town, state) <u>Washington Clinic, Wash DC</u> DATE SIGNED <u>9/12/59</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Youngblood, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/14/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10417

CERTIFICATE OF DEATH

10417

Married

Married

210 Main Street

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

April 12, 1903

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10418

10455

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8600 Manchester Rd</u>				d. STREET ADDRESS <u>8600 Manchester Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Calise</u> Last <u>Jerolaman</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22 1893</u>	
9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cosmetics retail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Aick</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Donald Jerolaman</u> Address <u>2009 Dayton St Silver Spring md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inhalation of smoke & fumes</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>Found dead in burning home</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4:20</u> <u>9-21 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 24 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Stobbs</u>				ADDRESS <u>WASH 12, D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH		5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS	
8. PRESENT ADDRESS 9. DATE OF DEATH 10. TIME OF DEATH		11. CAUSE OF DEATH 12. MANNER OF DEATH	
13. SIGNATURE OF MEDICAL EXAMINER 14. TITLE OF MEDICAL EXAMINER		15. SIGNATURE OF WITNESS 16. TITLE OF WITNESS	
17. SIGNATURE OF CLERK 18. TITLE OF CLERK		19. SIGNATURE OF JURY 20. TITLE OF JURY	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10456

CERTIFICATE OF DEATH

10419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11707 Berwick Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Edward Jetter</u>				4. DATE OF DEATH <u>Sept. 2</u> 19 <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/22 79</u>		9. AGE (In years last birthday) <u>79 83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIPPING CLERK FOR LARKUM CO. INMEXCO</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>LARKUM CO. INMEXCO</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Edward Jetter</u>				14. MOTHER'S MAIDEN NAME <u>E. Nunn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>071-05-1831</u>		INFORMANT Address <u>Eleanor Jetter, 11707 Berwick, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>Post-operative prostatectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2</u> 19 <u>59</u> to <u>9/2</u> 19 <u>59</u> that I last saw the deceased alive on <u>9/2</u> 19 <u>59</u> , and that death occurred at <u>5pm</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>909 PERSHING DRIVE, S.S.</u> DATE SIGNED <u>Arthur J. Wilets</u>							
ACTUAL SIGNATURE <u>Arthur J. Wilets</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>9/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOREST LAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BUFFALO, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Wilets</u>	

10:10

CERTIFICATE OF DEATH

10458

STATE OF NEW YORK

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.

10457

CERTIFICATE OF DEATH

Reg. Dist. No.

10420

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 hr - 44m.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Johnson</u> Middle <u>Ruth</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 - 1899</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u> YES	
13. FATHER'S NAME <u>Gustav Bredenberg</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Eleanor C Lind - Item # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>VIRUS PNEUMONIA WITH PLEURAL EFFUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> <u>8 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VIRUS PNEUMONIA WITH PLEURAL EFFUSION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>59</u> , to <u>Sept 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 11</u> , 19 <u>59</u> , and that death occurred at <u>11:59 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph O'Connor</u> M.D.		ADDRESS (Street, city or town, state) <u>9420 Old Georgetown Rd. Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Joseph O'Connor</u>		DATE SIGNED <u>11 Sept. 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>9/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Briton, Conn.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Monte. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Chilma G. Thomas</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

10457

10457

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Place of Birth, and Cause of Death. There are also sections for the attending physician and the funeral home. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10421

Reg. Dist. No.

10458

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u> c. LENGTH OF STAY IN lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. John Lawrence, office</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German Town</u> d. STREET ADDRESS <u>Rt. 1 # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gloria Louise Johnson</u>				4. DATE OF DEATH Month Day Year <u>Sept 22 1959</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-59</u>		9. AGE (In years last birthday) yrs. Months Days <u>8 11</u>		IF UNDER 1 YEAR Months Days <u>8 11</u>		IF UNDER 24 HRS. Hours Min. <u>11</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Doris Bever</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>—</u>						17. INFORMANT Address <u>Wiley Johnson, Germantown Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>upper Respiratory Infection</u> (c) <u>—</u> (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						<u>9-22-59</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>				22d. LOCATION (City, town, or county) (State) <u>Clarksburg - Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen, Barnesville, Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2069244XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8320 Yule Rd</u>		d. STREET ADDRESS <u>8320 Yule Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>C.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NE</u>	
11. BIRTHPLACE (State or foreign country) <u>NE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Lewis Carr</u>		14. MOTHER'S MAIDEN NAME <u>Ina Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Glen Ham, 3233 Normount Ave.</u>		Address <u>Baltimore 16, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Blersch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Blersch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Moberg</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Kline</u>	

10357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>75x-3</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>South Hills - Pittsburgh</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>		d. STREET ADDRESS <i>536 Oxford Blvd</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Strzisko</i> Last <i>Karcis</i>		4. DATE OF DEATH Month <i>9</i> Day <i>7</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-2-81</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <i>Czech</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>John S. Karcis</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. _____	
INFORMANT <i>Hospital Records</i>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>430.0</i> DUE TO <i>Acute endocarditis with thrombosis and abscess formation</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO <i>Abscess formation and infarction of spleen and kidneys</i> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>8-11-59</i> , 19____, to <i>9-6-59</i> , 19____, that I last saw the deceased alive on <i>9-6-59</i> , 19____, and that death occurred at <i>12:35 am</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard L. Clapp</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave Takoma Park, Md.</i> DATE SIGNED <i>9-7-59</i>	
PHYSICIAN'S NAME (Type) <i>Richard L. Clapp</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) _____	22b. DATE THEREOF <i>9-7-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Jefferson Memorial Park</i>	22d. LOCATION (City, town, or county) <i>Pittsburgh, Pa.</i> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Sawler's Sons, Wash. DC</i>		24a. REC'D BY REGISTRAR <i>SEP 9 59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 Russell Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>M ontg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u> d. STREET ADDRESS <u>6 Russell Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold Sherwood Kingsley</u>				4. DATE OF DEATH Month Day Year <u>Sept 19, 1959</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/2/1877</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) <u>Mass</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbridge Kingsley</u>						14. MOTHER'S MAIDEN NAME <u>Fannie Sherwood</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Clarice Griffith (daughter) Item 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>						DATE SIGNED <u>9/19/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank B. Garton</u> ADDRESS <u>Gaithersburg</u>						24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hanna</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

10425

10461

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				d. STREET ADDRESS <u>2818 Rittenhouse St. Washington D.C.</u>			
3. NAME OF DECEASED (Type or print) <u>Berenice Eva Kirby</u>				4. DATE OF DEATH <u>September 12 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>	
13. FATHER'S NAME <u>Ambrose Patten</u>				14. MOTHER'S MAIDEN NAME <u>Eva Gaspard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>521-28-2216</u>		17. INFORMANT <u>Mrs. Genevieve Angel</u> Address <u>Washington, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH: <u>15 min.</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>Sept 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u>				DATE SIGNED <u>9-12-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>				ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave Washington D.C.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				24. REC'D BY REGISTRAR <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE TO DEATH		DATE OF DEATH	
HOME		JAN 10 1901	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE		JAN 10 1901	
NAME OF DECEASED		SEX	
JOHN J. HARRIS		MALE	
AGE		RACE	
30		WHITE	
MARRIED		OCCUPATION	
YES		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
PLACE OF INTERMENT		CITY	
BALTIMORE		BALTIMORE	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
J. J. HARRIS		J. J. HARRIS	
ADDRESS		ADDRESS	
1234 BALTIMORE		1234 BALTIMORE	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
NAME OF REGISTRAR		NAME OF REGISTRAR	
J. J. HARRIS		J. J. HARRIS	
ADDRESS		ADDRESS	
1234 BALTIMORE		1234 BALTIMORE	
CITY		CITY	
BALTIMORE		BALTIMORE	
STATE		STATE	
MARYLAND		MARYLAND	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10426

10462

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery M C 051		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8½ hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md				d. STREET ADDRESS 1109 Lewis Avenue	
3. NAME OF DECEASED (Type or print) First Cecelia Middle Irene Last KOVARIK		4. DATE OF DEATH Month September Day 26 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-59		9. AGE (In years lost birthday) yrs. 8 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Clifford Vincent KOVARIK			14. MOTHER'S MAIDEN NAME Juanita Joanne GOVAI		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Clifford Vincent KOVARIK Same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apnea 776 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Prematurity DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 min 8½ hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Sept , 19 59 , to 26 Sept , 19 59 that I last saw the deceased alive on 26 Sept , 19 59 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md DATE SIGNED 9-26-59					
ACTUAL SIGNATURE Kenneth W. Sell		PHYSICIAN'S NAME (Type) K. W. SELL LT MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-59		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
22d. LOCATION (City, town, or county) (State) Silver Spring Md.		24a. REC'D BY REGISTRAR SEP 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kinn	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Rockville, Maryland 1331 E. Montgomery Ave.					

2051274XV5

0000

Between (Hunt) 10 hours

U.S. Naval Hospital, Bethesda, Md. 10 hours

10 hours 10 hours 10 hours

None None None

C. Elford Vincent, KOWALIK

None None

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10427

10463

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alle. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Noewood Rd.				d. STREET ADDRESS 11 S. Lee St.			
3. NAME OF DECEASED (Type or print) First Marie E. Middle Lashley Last				4. DATE OF DEATH Month Sept Day 6 Year 1959 19			
5. SEX female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/14/1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md. Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. Wagner				14. MOTHER'S MAIDEN NAME Costelle Martz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Walter Lashley Address Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetis Mellitus 4 mo. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-1959		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 10 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

10464

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Avenue Kensington Gardens Nursing Home		d. STREET ADDRESS 1409 Buchanan Street, N.W.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last LEAMAN		4. DATE OF DEATH Month SEPT Day 20 Year 19 59	
5. SEX M	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Builder		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JAMES E. LEAMAN.		14. MOTHER'S MAIDEN NAME MATILDA GLOYD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Records at Nursing Home-Kensington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PASSIVE CONGESTION OF HEART 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 MIN 10 YEARS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 6 , 19 59 , to SEPT 20 , 19 59 , that I last saw the deceased alive on SEPT 17 , 19 59 , and that death occurred at 4:53 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4501 CONN AVE D.C. DATE SIGNED 9/20/59 ACTUAL SIGNATURE Robert S. Poole M.D. PHYSICIAN'S NAME (Type) ROBERT S. POOLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/59	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR SEP 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10684

Residence of Deceased

Place of Death

LEAHMAN, E.

E.

JOSEPH

33

CAU

M

(MARRIED)

LEAHMAN, E.

JAMES E. LEAHMAN

THESE CERTIFICATE OF DEATH

INTERESTING HEART DISEASE

ANALYSIS HISTOLOGICAL

DATE OF BIRTH

DECEASED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10429

10358 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
TOWN <u>Takoma Park</u>				TOWN <u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517-Albany Ave.</u>				STREET ADDRESS (If rural give location) <u>517-Albany Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>LUCY</u> (Middle) <u>REBECCA</u> (Last) <u>LEECH</u>				SEPT. 30, 19 <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 20, 1875</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months <u>10</u>	Days <u>10</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ephraim Carlos Merriam</u>				14. MOTHER'S MAIDEN NAME <u>Helen Wirt White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Tim Linville - Schenectady, N.Y.</u> <u>Nephew</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
450.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>							<u>1 day</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerosis</u>							<u>Indefinite</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 12, 1959</u> to <u>Sept 30, 1959</u> that I last saw the deceased <u>alive on</u> <u>Sept 30, 1959</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>M. D. Linville</u> DATE SIGNED <u>9/30/59</u> ADDRESS (Street, city, town, state) <u>1511 15th St. N.W. Wash. D.C.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10/5/1959</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) <u>DC</u>	
24. REC'D BY REGISTRAR <u>OCT 5 2 '59</u>		REGISTRAR'S SIGNATURE <u>Charles A. Kinard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>		ADDRESS <u>60 - Wash. D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10439

10465

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Springfield c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7612 Kedron Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley Virginia LELAND		4. DATE OF DEATH Month Day Year September 5 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 January 1924
9. AGE (In years last birthday) yrs. 35		10. IF UNDER 1 YEAR Months Days Hours Min. 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY housewife	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Arthur MANDERS		14. MOTHER'S MAIDEN NAME Virginia N. GRATHERAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT (Husband) Harry E. LELAND Same as #2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170X 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Aug. 19 59 to 5 September 59 that I lost saw the deceased alive on 5 September 19 59 and that death occurred at 3:12 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 9-5-59 ACTUAL SIGNATURE C.W. Bramlett M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) C.W. BRAMLETT LT MC USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE LEE Funeral Home 4th & Mass Ave. N.E. Washington, D.C.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE SEP 9 '59 Arthur L. Kraus	

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U.S. NAVY HOSPITAL, BETHESDA, MD.

CERTIFICATE OF DEATH

10463

Virginia

Bethesda (Maryland) 10 days

U.S. Naval Hospital Bethesda, Md. 1015 Madison Street

Sperry Virginia Island

Female 10 days 1 January 1954

Housewife 10 days 1 January 1954

Virginia M. CHRISTIAN

10 days 1 January 1954

(Sperry) Harry E. BELAND Home 10 days

No

10 days 1 January 1954

10 days

10 days

10 days

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. NAVY HOSPITAL, BETHESDA, MD.

Attest: Virginia

Attest: National

10 days

10 days 1 January 1954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10466

Item 5 Film 6249 9-23-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5yr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4712 Overbrook Rd</u>				/d. STREET ADDRESS <u>4712 Overbrook Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Lewis</u> Last <u>Lembcke</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-18-86</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret Art Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>M-S-C</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>EDWARD</u> <u>Glanville Coneys</u>				14. MOTHER'S MAIDEN NAME <u>Clara Tippet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u>578-14-644</u>			
17. INFORMANT <u>Robert Lembcke</u>				Address <u>Stim 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-26-1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paulsen</u>				24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

Frank J. Brosehart

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. BROSEHARTASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒9-23-59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10467

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY LESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henrietta Middle LESTER Last LESTER				4. DATE OF DEATH Month September Day 11 Year 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-17-11	
9. AGE (In years last birthday) 47 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas TROUTMAN		14. MOTHER'S MAIDEN NAME Georgia LAUREL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 518X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Broncho-pleural Fistula + atelectasis of Rt. Lower Lobe							INTERVAL BETWEEN ONSET AND DEATH 1 MIN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 2 , 19 59 , to Sept. 11 , 19 59 , that I last saw the deceased alive on Sept. 11 , 19 59 , and that death occurred at 2:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 9-12-59							
ACTUAL SIGNATURE R. G. Muth		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-14-59		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORY Montezuma		22d. LOCATION (City, town, or county) (State) Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Snowden Funeral Home, Rockville, Md.				24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10267

Maryland

Montgomery

2 days 2 days (burial) Lexington Park

U. S. Naval Hospital 10 Main Ave.

LESTER

ROCKVILLE

9-17-11

Thomas H. H. H. H.

Georgia

Honolulu

Georgia

Thomas H. H. H.

Hospital Records

No.

Georgia

Thomas H. H. H.

Georgia

Thomas H. H. H.

Georgia

Thomas H. H. H.

Georgia

Thomas H. H. H.

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Thomas H. H. H.

Georgia

Thomas H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10468

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route #1 Travilah Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peggy Sue Liker</u>				4. DATE OF DEATH Month Day Year <u>9 20 1959</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-18-59</u>	9. AGE (In years last birthday) yrs. <u>8</u> Months <u>2</u> Days <u>2</u> Hours <u>0</u> Min.	IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>			IF UNDER 24 HRS. Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Frank Liker</u>				14. MOTHER'S MAIDEN NAME <u>Williams</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Rockville Md.</u> <u>Elinora Williams Rt #1 Travilah Road</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Aspiration pneumonia</u> 917.0 DUE TO <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>—</u> (c) <u>1st-2nd+3rd degree burns (35%)</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 days</u> <u>5 days</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enterococci</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child pulled from hot water oven self</u>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>11:40 9-15 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Monty Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-21-59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>William A. Frank</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10434

CERTIFICATE OF DEATH

Reg. Dist. No.

10359

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Washington, D. C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7300 Baltimore Ave						d. STREET ADDRESS 3420 -16th St. N.W. Apt. 303						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Grace MacCurdy		4. DATE OF DEATH Month Day Year Sept 13 1959		5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/19/1878		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse						10b. KIND OF BUSINESS OR INDUSTRY --						11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Johnston						14. MOTHER'S MAIDEN NAME Laura Williams						15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none						17. INFORMANT Joseph F. MacCurdy						Address 3420 -16th St. N.W. Washington, D. C. Apt. 303			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hiatal Hernia														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from August 4, 1959 , to Sept 13, 1959 , that I last saw the deceased alive on Sept 13, 1959 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE James M. Whitlock						ADDRESS (Street, city or town, state) DATE SIGNED 2701 Carroll Ave 9-13-59									
PHYSICIAN'S NAME (Type) James M. Whitlock						ADDRESS Takoma Park Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				22d. LOCATION (City, town, or county) (State) Prince Georges Co. Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.						ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kinner					

CERTIFICATE OF DEATH

Reg. Dist. No.

10435

10469

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Infant) PATRICIA DENISE MADINE</u>		4. DATE OF DEATH Month Day Year <u>Sept. 25 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/16/59</u>
9. AGE (In years last birthday) <u>10 days</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md - (Bethesda)</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES J. MADINE</u>		14. MOTHER'S MAIDEN NAME <u>Helen Augusta Caulfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Chart. (Hosp. Records)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Anomaly</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 16, 1959</u> , to <u>Sept. 25, 1959</u> , that I last saw the deceased alive on <u>Sept. 25, 1959</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. H. Bergstrom</u> M.D.		DATE SIGNED <u>Rockville Medical Center 9-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Clippers, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg MD. RAD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edenton</u> ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>

2074212XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1943

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1

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of filing: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10436

Reg. Dist. No.

10374

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>8 yrs</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (Rural)</u> d. STREET ADDRESS <u>Glen Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Florence Lillian Eva Marks</u>				4. DATE OF DEATH Month Day Year <u>Sept 25 - 1959</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-1881</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Real Estate</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Wm T. Queen</u>						14. MOTHER'S MAIDEN NAME <u>Mary Hardy</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Frances Hallings</u> Address <u>Stim 2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c), stating the underlying cause last. DUE TO												INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						9-25-59					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>9-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Hartmann & Son Funeral Home</u> ADDRESS <u>5737 Eu. Ave. Wash. 11</u>										24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10437

10360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Pri. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	
c. LENGTH OF STAY IN 1b 3 DAYS		1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN & HOSP. T.P.-12		d. STREET ADDRESS 2111 GUILFORD RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DONNA Middle MARSHALL Last MARSHALL		4. DATE OF DEATH Month 9 Day 16 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-59
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U-S-A	
13. FATHER'S NAME JACK B. MARSHALL		14. MOTHER'S MAIDEN NAME VIVIAN BART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT WASH. SAN & HOSP. RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 756.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suppurative Aneurysm & aneurysm DUE TO (c) Since birth		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12, 1959 , to Sept 16, 1959 , that I last saw the deceased alive on Sept 16, 1959 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lyle Williams		ADDRESS (Street, city or town, state) DATE SIGNED 8700 Colesville Rd Silver Spring, Md. Sept 16, 1959	
PHYSICIAN'S NAME (Type) Lyle Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/59	22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	22d. LOCATION (City, town, or county) (State) Gaithersburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Harris		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR DATE SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Harris	

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CERTIFICATE OF DEATH

NO. 1000

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		M		35		JAN 5 1928		MOBILE, ALABAMA	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
SALES MAN		HEART DISEASE		NATURAL		HOSPITAL		10:00 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. NAME OF HOSPITAL		17. NAME OF PHYSICIAN		18. NAME OF REGISTRAR		19. NAME OF WITNESS		20. NAME OF DECEASED	
[Name]		[Name]		[Name]		[Name]		[Name]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

CERTIFICATE OF DEATH

Reg. Dist. No.

10438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 Marvin Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>L.</u> Last <u>Martell</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 6, 1867</u>	
9. AGE (In years last birthday) <u>92 yrs</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker, retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Quebec, Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u> <u>Leville</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address (Spring, Md.) <u>Mrs. Ralph S. Sadler, 303 Marvin Rd., Silver</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 3, 1957</u> to <u>Sept. 26, 1959</u> that I last saw the deceased alive on <u>Sept. 26, 1959</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D.				ADDRESS (Street, city or town, state) <u>345 University Blvd, West 9/26/59</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				DATE SIGNED <u>Silver Spring, Md.</u>			
22a. MANNER OF CREMATION, REMOVAL (Specify) <u>Oct. 1, 1959</u>		22b. DATE OF DEATH <u>Burial</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Monroe, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>SEP 29 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10439

10471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>E.</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/81</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. DC</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES THOMAS MOHLER</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth HARVEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. ADDRESS <u>Mr. S. Martin, 1417 K St. N.W.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Acute pyelonephritis, severe</u> DUE TO (c) <u>4 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/3/59</u> to <u>9/5/59</u> , that I last saw the deceased alive on <u>9/5/59</u> at <u>6:15 PM</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard C. Myers</u>		ADDRESS (Street, city or town, state) <u>8512 old Georgetown Rd. Bethesda</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD C. MYERS</u>		DATE SIGNED <u>SEP 9 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>		ADDRESS <u>1700 Chapin St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,		c. LENGTH OF STAY IN 1b 26		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, M		d. STREET ADDRESS 114 Frederick Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARMEN Middle M. Last MASON		4. DATE OF DEATH Month Sept. Day 12, Year 19 59		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1904		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Charles A. Hill		14. MOTHER'S MAIDEN NAME Katie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT James A. Mason		Address Item 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Probable coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Hypertensive cardiovascular disease. 5 years DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville, Md.		(County)		(State)			
21. I certify that I attended the deceased from March 8, 1957 , to Sept. 12, 1959 , that I last saw the deceased alive on Sept. 11, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above.													
ACTUAL SIGNATURE W. H. Lenthum		M.D.		ADDRESS (Street, city or town, state) 26 N. Summit Ave.		DATE SIGNED 9/12/59							
PHYSICIAN'S NAME (Type) Lenthum, W. H.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National,		22d. LOCATION (City, town, or county) Arlington, Va.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swower		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

2502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 15, Film G-249 9/24/59.cac.

10441

10472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Betterton d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Lincoln Last McBride		4. DATE OF DEATH Month September Day 18, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1893
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months 65 Days 14 Hours X Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles McBride		14. MOTHER'S MAIDEN NAME Amanda Sneed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Yes World War I		16. SOCIAL SECURITY NO. 220-01-8565	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic bronchopneumonia DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelogenous leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subacute bacterial endocarditis, aortic valve		INTERVAL BETWEEN ONSET AND DEATH days 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16, 19 59 , to September 18, 19 59 , that I last saw the deceased alive on September 18, 19 59 , and that death occurred at 9:50 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-19-59			
ACTUAL SIGNATURE Jerry S. Trier		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9/22/59	
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Cunningham		24a. REC'D BY REGISTRAR DATE SEP 24 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Carlton G. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10442

10473

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Summerhill d. STREET ADDRESS Box 205 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Jerome McCall			4. DATE OF DEATH Month Day Year September 11, 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1936		9. AGE (In years last birthday) yrs. 23		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME Thomas McCall			14. MOTHER'S MAIDEN NAME Esther Noon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 210-28-7674		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Malignant Carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 Months 1 Year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from August 25, 1959 , to September 11, 1959 , that I last saw the deceased alive on September 11, 1959 , and that death occurred at 3:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 9/11/59							
ACTUAL SIGNATURE Charles E. Mengel		PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Temp 9-14-59		22b. DATE THEREOF 9-14-59		22c. NAME OF CEMETERY OR CREMATORY ST MARYS			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 15 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 2

10

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G249 10-13-59 et

11590

CERTIFICATE OF DEATH

Reg. Dist. No.

10474

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flushing New York</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANIT.</u>		d. STREET ADDRESS <u>143-54 Roosevelt Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>D. J.</u> Last <u>McCarthy</u>		4. DATE OF DEATH Month <u>9-</u> Day <u>29-</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Respiratory failure</u>		<u>24 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchus Pneumonia</u> DUE TO (c) <u>Cerebral Thromboses</u>		<u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>59</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Jagger Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave</u> DATE SIGNED <u>9/29/59</u>	
PHYSICIAN'S NAME (Type) <u>Chevy Chan (S, Md.)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/29/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Hawthorne Funeral Home - 3831 - G St. Ave.</u>		22d. LOCATION (City, town, or county) (State) <u>New York N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Kashington Gardens 143-24-1000 New York

William D. I. McCord

143-24-1000 New York

Longstanding business

(order - 1000)

New York

1/20/51
143-24-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10443

Reg. Dist. No.

10475

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Fairborn			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 105 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 64 North Wright Avenue			
3. NAME OF DECEASED (Type or print) Grover William McCoy				4. DATE OF DEATH September 30 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1892		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk				10b. KIND OF BUSINESS OR INDUSTRY Government (Retired)		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Joseph McCoy			
14. MOTHER'S MAIDEN NAME Evangeline West				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. Unascertainable				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-resp. Arrest 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant metastatic carcinoid DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 17 , 19 59 , to September 30 , 19 59 , that I last saw the deceased alive on September 30 , 19 59 , and that death occurred at 3:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/1/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles S. Mengel M.D.				PHYSICIAN'S NAME (Type) Charles S. Mengel, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 10/1/59				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) Dayton, Ohio							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE OCT 5 2 '59		24b. REGISTRAR'S SIGNATURE Charles S. Mengel	

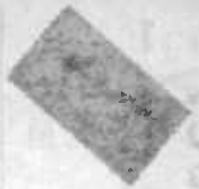
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10475



Name of Deceased		John H. Jones	
Sex		Male	
Age		65 years	
Date of Birth		January 15, 1880	
Place of Birth		Baltimore, Md.	
Usual Residence		1234 North Avenue, Baltimore, Md.	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Physician		Dr. J. H. Smith	
Burial Place		Greenwood Cemetery, Baltimore, Md.	
Date of Burial		January 25, 1945	
Signature of Physician		J. H. Smith	
Signature of Registrar		J. H. Jones	
Date of Certificate		January 26, 1945	

10476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>18 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>McMill</u> Last <u>McMill</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/9/92</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sov. Printing Office Planner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Patrick McMill</u>				14. MOTHER'S MAIDEN NAME <u>Mary Galligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Army</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Wife (same as above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased Intracranial Pressure</u> 332x DUE TO <u>Cerebral Infarct (Left frontal lobe)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with intraventricular hemorrhage</u> DUE TO (c) <u>20 hours</u> 6 weeks 20 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>September 19, 1959</u> to <u>Sept 29, 1959</u> that I last saw the deceased alive on <u>Sept 28, 1959</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael M. Healy</u>				DATE SIGNED <u>9/29/59</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>				ADDRESS (Street, city or town, state) <u>Washington Clinic Wash DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10445

10477

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47 X-3</u> d. STREET ADDRESS <u>1351 Girard ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>?</u> Last <u>McKinley</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>19 59</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>45?</u> yrs.		IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u>		IF UNDER 24 HRS. Hours <u>?</u> Min. <u>?</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>				11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown). <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>				17. INFORMANT <u>Alice Miles (Foster mother)</u> Address <u>1351 Girard ST. Wash. D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bremia</u> DUE TO <u>910.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal failure</u> DUE TO <u>Chesh Injuries</u> (c) <u>10 Days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2 Days</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crushed on collapse of construction job.</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> a.m. <u>8-22</u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>bedg.</u>		20f. (City or town) <u>Bethesda</u>		(County) <u>montg</u>		(State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>9-2-59</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-5-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland Rd. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall Bros.</u>						ADDRESS <u>621 Fla. ave NW</u>						24a. REC'D BY REGISTRAR <u>SEP 4 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF MEDICAL EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
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73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

796

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10446

Reg. Dist. No.

10361

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16 15-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>8423 New Hampshire Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Virginia</u> Last <u>Michael</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-82</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Weather George Burton</u>			14. MOTHER'S MAIDEN NAME <u>Riesmeisel</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Did not have one</u>		17. INFORMANT Address <u>Mrs. C. M. Bessi - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus (several years)</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-17-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept. 21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>254 Carroll St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carling B. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10478

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 627 Forrester St. SE			
3. NAME OF DECEASED (Type or print) First Peter Middle Madison Last MINCEY				4. DATE OF DEATH Month September Day 6 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 May 1956		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY child		11. BIRTHPLACE (State or foreign country) Hawaii		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Andrew Van MINCEY				14. MOTHER'S MAIDEN NAME Lavon MCDOUGALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) C NO		16. SOCIAL SECURITY NO. (Father) Andrew Van MINCEY Same as #2		INFORMANT Address (Father) Andrew Van MINCEY Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent meningitis and bacterial pneumonia 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus with ventriculo-jugular shunt							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 Aug 1959 to 6 Sept. 1959 that I last saw the deceased alive on 6 Sept. 1959 and that death occurred at 1:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-7-59							
ACTUAL SIGNATURE AB Avery		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) G.B. AVERY, LT MC USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home				24a. REC'D BY REGISTRAR DATE SEP 9 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kneale	

1

Page 4

death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
ISM 9/58

Montgomery
Baltimore (Maryland)
U.S. Naval Hospital, Bethesda, Md. 327
Veteran
White
14 MAY 1950
Hawaii
U.S.
Andrew Van NIMICK
Laven MODOGALLI
(Father) Andrew Van NIMICK same as 42

6 Sept.
21 Aug.
29 6 Sept.
U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.

Montgomery Co., Deputy Medical Examiner notified.

10479 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 5719 29th St., West		1615-2			
3. NAME OF DECEASED (Type or print) First Ruth		Middle Nelson		Last MOORE		4. DATE OF DEATH Month September		Day 15	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-12		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Chester NELSON		14. MOTHER'S MAIDEN NAME Charlotte DIETZ		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (H) Geo. L. Moore, same as #2 above		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Anaplastic carcinoma, site undetermined, with widespread metastases to lung, brain and abdominal organs Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) 199.2 (c) 199.2		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour g. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda		(County) Prince Georges		(State) Md.		21. I certify that I attended the deceased from May 26 , 19 59 , to Sept. 15 , 19 59 , that I last saw the deceased alive on Sept. 13 , 19 59 , and that death occurred at 12:25 A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U. S. Naval Hospital	
ACTUAL SIGNATURE Pauline P. Clarke		DATE SIGNED 9-15-59		PHYSICIAN'S NAME (Type) P. E. CLARKE, LCDR, MC, USN		Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-19-59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey		ADDRESS Rumal Home, Silver Spring		24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

10478

Montgomery

Tennessee (Nash)

DOA

Hastingsville

Maryland

U. S. Naval Hospital

2719 28th St., West

Birth

Nelson

MOORE

30-11-12

Family - Caucasian

3-11-12

Hoodsville

New York

U.S.A.

Charles Nelson

Complete Data

No

(1)

Geo. I. Moore, name as above

Prognosis: fatal
Anaplastic carcinoma, site undetermined,
with widespread metastases to lung, brain
and abdominal organs

RECEIVED BY THE NATIONAL BUREAU OF INVESTIGATION

Death

9-12-22

Pathology Laboratory

Hoodsville, Maryland

Dr. E. E. Clark, M.D., U.S.N.

Tennessee, Maryland

Sept. 13

Aug. 25

Sept. 13

U. S. Naval Hospital

2719 28th St., West

9-12-22

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 262, 5/9/60-ams)

10480

CERTIFICATE OF DEATH

10449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Birmingham			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Birmingham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 42 Edgemoor Road			
3. NAME OF DECEASED (Type or print) First Ray Middle Clarence Last Mork				4. DATE OF DEATH Month September Day 1 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1900	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrator		10b. KIND OF BUSINESS OR INDUSTRY Medical Journal		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Reuben Mork		14. MOTHER'S MAIDEN NAME Clara Kittelson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 577-42-9978		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure DUE TO (b) Isolated Heart Disease with Aortic Insufficiency of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. unknown origin DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from August 25, 19 59 , to September 1, 19 59 , that I last saw the deceased alive on September 1, 19 59 , and that death occurred at 10:15 P. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor W. Sidel M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-2-59			
PHYSICIAN'S NAME (Type) Victor W. Sidel, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Himes Co., 2901 14th St., N.W.				24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Himes	

5270 • J. Neurosci., September 24, 2008 • 28(39):5265–5272

CERTIFICATE OF DEATH

Reg. Dist. No.

10450

10481

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			
c. LENGTH OF STAY IN TB 16 hours				d. STREET ADDRESS 108 King William Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Frances Last Motley				4. DATE OF DEATH Month 9 Day 5 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3.28.1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72		IF UNDER 24 HRS. Days 72 Hours 72 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Denis O'Neill				14. MOTHER'S MAIDEN NAME Catherine Downing			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 725.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arthritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1958 , 19____, to Sept 4 , 19 59 , that I last saw the deceased alive on Sept 4 , 19 57 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/5/59 ACTUAL SIGNATURE Richard A. Yates M.D. PHYSICIAN'S NAME (Type) Richard A. Yates, M. D. Olney, Maryland 9.5.59 22a. BURIAL, CREMATION, REMOVAL (Specify) 9-8-59 22b. DATE THEREOF State of Maryland 22c. NAME OF CEMETERY OR CREMATORY Olney, Maryland 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE Anthony Hanlon ADDRESS 3831 Ga Ave NW 24. REC'D BY REGISTRAR DATE SEP 18 '59 25. REGISTRAR'S SIGNATURE Arthur J. Evans							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See last page

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10362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D. C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Eventide Nursing Home				d. STREET ADDRESS 1750 Harvard St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MARIA Middle T Last MORSE		4. DATE OF DEATH Month 9 Day 25 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist at Bureau of Standards		10b. KIND OF BUSINESS OR INDUSTRY of Standards		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Morse				14. MOTHER'S MAIDEN NAME Louise Parish Townsend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mrs. Florence Greble New York, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO organ not known (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Arteriosclerosis, high blood pressure, Diabetes				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan 9/24/1940 to 9/24/1959 , that I last saw the deceased alive on 9/24/1959 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas H Wolohan		M.D.		ADDRESS (Street, city or town, state) 760 Carroll Lane		DATE SIGNED 9/25/59	
PHYSICIAN'S NAME (Type) Chas H Wolohan				Takoma Park Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal		22b. DATE THEREOF 19-28-59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) BROOKLYN N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawlars Sons, Wash. D.C.				24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Name of Deceased: *John Doe*
 Date of Death: *10/15/1918*
 Place of Death: *Home*
 Cause of Death: *Heart Disease*
 Age: *45*
 Sex: *Male*
 Race: *White*
 Occupation: *Farmer*
 Signature of Physician: *[Signature]*
 Date of Certificate: *10/16/1918*
 Registrar: *[Signature]*
 Date of Registration: *10/16/1918*

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G250 10-19-59 et

CERTIFICATE OF DEATH

10452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 MOS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MAJOR HOME		d. STREET ADDRESS HILLDALE ROAD	
3. NAME OF DECEASED (Type or print) SIMON First — Middle MOSE Last		4. DATE OF DEATH SEPT. Month 20 Day 1959 Year	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Herman		14. MOTHER'S MAIDEN NAME Rebecca	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT DR L. M. MOSER Address BETHESDA, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON'S DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. st. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST , 19 54 , to SEPT. , 19 59 , that I last saw the deceased alive on SEPT. 29 , 19 59 , and that death occurred at 4 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth M Moser		DATE SIGNED 9/20/59	
PHYSICIAN'S NAME (Type) M.D.		9420 BULLS RUN PKWY BETH. -14, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-59	
22c. NAME OF CEMETERY OR CREMATORY Ober Shalom		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc		ADDRESS 2100 Eutaw Pl	
24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE C. J. H. H. H.	

CERTIFICATE OF DEATH

10082

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF DEATH BALTIMORE	
3. DATE OF DEATH JAN 10 1908		4. TIME OF DEATH 10:00 AM	
5. SEX Male		6. AGE 45	
7. OCCUPATION Carpenter		8. MARITAL STATUS Married	
9. PLACE OF BIRTH Maryland		10. COLOR White	
11. EDUCATION High School		12. RELIGION Roman Catholic	
13. PRESENT ADDRESS 1234 Main St, Baltimore		14. DATE OF BIRTH Jan 10 1863	
15. DATE OF DEATH Jan 10 1908		16. TIME OF DEATH 10:00 AM	
17. PLACE OF DEATH Home		18. CAUSE OF DEATH Heart Disease	
19. MANNER OF DEATH Natural		20. SIGNATURE OF PHYSICIAN J. H. Harris	
21. SIGNATURE OF WITNESSES J. H. Harris		22. SIGNATURE OF CORONER J. H. Harris	
23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF NEXT OF KIN J. H. Harris	
25. SIGNATURE OF CLERK J. H. Harris		26. SIGNATURE OF JURY J. H. Harris	
27. SIGNATURE OF JURY J. H. Harris		28. SIGNATURE OF JURY J. H. Harris	
29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JURY J. H. Harris	
31. SIGNATURE OF JURY J. H. Harris		32. SIGNATURE OF JURY J. H. Harris	
33. SIGNATURE OF JURY J. H. Harris		34. SIGNATURE OF JURY J. H. Harris	
35. SIGNATURE OF JURY J. H. Harris		36. SIGNATURE OF JURY J. H. Harris	
37. SIGNATURE OF JURY J. H. Harris		38. SIGNATURE OF JURY J. H. Harris	
39. SIGNATURE OF JURY J. H. Harris		40. SIGNATURE OF JURY J. H. Harris	
41. SIGNATURE OF JURY J. H. Harris		42. SIGNATURE OF JURY J. H. Harris	
43. SIGNATURE OF JURY J. H. Harris		44. SIGNATURE OF JURY J. H. Harris	
45. SIGNATURE OF JURY J. H. Harris		46. SIGNATURE OF JURY J. H. Harris	
47. SIGNATURE OF JURY J. H. Harris		48. SIGNATURE OF JURY J. H. Harris	
49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JURY J. H. Harris	
51. SIGNATURE OF JURY J. H. Harris		52. SIGNATURE OF JURY J. H. Harris	
53. SIGNATURE OF JURY J. H. Harris		54. SIGNATURE OF JURY J. H. Harris	
55. SIGNATURE OF JURY J. H. Harris		56. SIGNATURE OF JURY J. H. Harris	
57. SIGNATURE OF JURY J. H. Harris		58. SIGNATURE OF JURY J. H. Harris	
59. SIGNATURE OF JURY J. H. Harris		60. SIGNATURE OF JURY J. H. Harris	
61. SIGNATURE OF JURY J. H. Harris		62. SIGNATURE OF JURY J. H. Harris	
63. SIGNATURE OF JURY J. H. Harris		64. SIGNATURE OF JURY J. H. Harris	
65. SIGNATURE OF JURY J. H. Harris		66. SIGNATURE OF JURY J. H. Harris	
67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JURY J. H. Harris	
69. SIGNATURE OF JURY J. H. Harris		70. SIGNATURE OF JURY J. H. Harris	
71. SIGNATURE OF JURY J. H. Harris		72. SIGNATURE OF JURY J. H. Harris	
73. SIGNATURE OF JURY J. H. Harris		74. SIGNATURE OF JURY J. H. Harris	
75. SIGNATURE OF JURY J. H. Harris		76. SIGNATURE OF JURY J. H. Harris	
77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris	
81. SIGNATURE OF JURY J. H. Harris		82. SIGNATURE OF JURY J. H. Harris	
83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
85. SIGNATURE OF JURY J. H. Harris		86. SIGNATURE OF JURY J. H. Harris	
87. SIGNATURE OF JURY J. H. Harris		88. SIGNATURE OF JURY J. H. Harris	
89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris	
93. SIGNATURE OF JURY J. H. Harris		94. SIGNATURE OF JURY J. H. Harris	
95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris	
99. SIGNATURE OF JURY J. H. Harris		100. SIGNATURE OF JURY J. H. Harris	



MAINTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 22 Film G249 9/24/59 1wk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>4004 29th ST</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Murray</u>				4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Murray</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Miss Mary Johnson</u> Address <u>4004 29th Mt. Rainier Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enter Cranial Hemorrhage</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> o. m. <u>9-16</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Mt Rainier - P.G. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10483

CERTIFICATE OF DEATH

Reg. Dist. No.

10454

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Campbell ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lorene Middle — Last Myers				4. DATE OF DEATH Month September Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1928	
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —		11. IF UNDER 24 HRS. Months — Days — Hours — Min. —		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Tennessee				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Dock Adkins				14. MOTHER'S MAIDEN NAME Minnie Goad			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 193-20-7098			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative - Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) Mitral Insufficiency and Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 30, 1959 to September 15, 1959 , that I last saw the deceased alive on September 15, 1959 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED SEP 17 '59							
ACTUAL SIGNATURE Kenneth O. Carney, M.D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Kenneth O. Carney, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/59		22c. NAME OF CEMETERY OR CREMATORY Sharp Cemetery		22d. LOCATION (City, town, or county) (State) Campbell County, Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR SEP 17 '59				24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

10 years	Operative - Cardiac Arrest
10 years	Rheumatic Heart Disease
10 years	Myocardial Infarction and Stenosis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10484
CERTIFICATE OF DEATH

10455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 427 Pershing Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park d. STREET ADDRESS 17603 Eastern Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian Mary O'Neil		4. DATE OF DEATH Month Day Year September 20, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/80
9. AGE (In years and birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Meister		14. MOTHER'S MAIDEN NAME Louise Muhlstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-26-0141	
17. INFORMANT Harry O'Neil		18. ADDRESS 8807 Bradford Rd Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 154X DUE TO (b) Carcinomatosis DUE TO (c) Primary Adeno-Carcinoma of rectum		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 8 mo. 10 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24, 1954 to Sept 20, 1959 , that I last saw the deceased alive on Sept 19, 1959 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George L. Ball (M.D.)		ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring Md	
PHYSICIAN'S NAME (Type) George L. Ball		DATE SIGNED Sept 20 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/23/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur E. Hines		DATE SEP 22 '59	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10000

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of attending physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10456

Reg. Dist. No.

10485

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COPPERSBURG 75X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,020 MENLO AVENUE				d. STREET ADDRESS ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FILI First PECHACEK Middle Last				4. DATE OF DEATH Month SEPT. Day 26 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1/6/80		9. AGE (In years last birthday) 79 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER OF HOTEL (RETIRED) HOTEL				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH JASEK				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miss Angela Pechacek, Route #2 Coppersburg, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 9/26/59							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		9/30/59		CALVARY EMETERY		LIMEPOST, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. <i>Raymond A Ziska</i>				24a. REC'D BY REGISTRAR DATE SEP 28 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1953

WINTER 2

10,750 - 110 AND AVE

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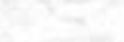
10,750 - 110 AND AVE

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10,750 - 110 AND AVE

Coroner's decision



Coroner's decision



CERTIFICATE OF DEATH

Reg. Dist. No.

10486

10457

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Resh Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First E Middle Peebles Last		4. DATE OF DEATH Month 9 Day 2 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 5 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Ibels		14. MOTHER'S MAIDEN NAME Amelia Roelker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Leighton H Peebles, Husband-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral cortical atrophy, severe DUE TO (c) Cerebral arteriosclerosis, severe			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 5 yrs + 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 , to Sept 2, 1959 , that I last saw the deceased alive on Aug 31, 1959 , and that death occurred at 6:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		DATE SIGNED 9-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 98/4/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon Papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

10486

Postmortem

1-1-1900

Report on Section West Side

Anna

F. W.

March 9, 1887

Germany

Joseph, Israel

Home

Cerebral thrombosis

Cerebral aneurysm

Cerebral aneurysm

APR 31

St. Louis

St. Louis

1887

St. Louis

Robert A. Thompson, M.D., St. Louis

10487

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Oakly</u> Last <u>Penn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30-1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Towson - Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Joseph Peregron</u>				14. MOTHER'S MAIDEN NAME <u>Louise Oakly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hosp. records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hematuria - Undetermined Cause</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>7-3-</u> <u>1959</u> , to <u>9-17-</u> <u>1959</u> , that I last saw the deceased alive on <u>9-14-</u> <u>1959</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roy B. Persons Jr.</u>				ADDRESS (Street, city or town, state) <u>Burtonsville Md</u>			
PHYSICIAN'S NAME (Type) <u>Roy B. Persons Jr.</u>				DATE SIGNED <u>9-17-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 21-1959</u>		<u>St. Mary's (Hampden)</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u>				ADDRESS <u>3631 Falls Road</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Fink</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>WILLIAM BROWN</u></p>	
<p>2. Date of death: <u>1918</u></p>	
<p>3. Place of death: <u>at home</u></p>	
<p>4. Cause of death: <u>influenza</u></p>	
<p>5. Age: <u>45</u></p>	
<p>6. Sex: <u>male</u></p>	
<p>7. Race: <u>white</u></p>	
<p>8. Occupation: <u>carpenter</u></p>	
<p>9. Residence: <u>1234 Main St. Baltimore, Md.</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of registration: <u>1918</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10459

Reg. Dist. No.

10364

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 TULIP AVE				d. STREET ADDRESS 1 506 TULIP AVE			
3. NAME OF DECEASED (Type or print) First JACOB Middle FRANKLIN Last PESTER				4. DATE OF DEATH Month SEPT Day 4 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11-1870		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) White Water, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. Leroy Pester				14. MOTHER'S MAIDEN NAME Eleanor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Pearl A. Pester Address 506 Tulip Ave Takoma Park			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Pernicious Anemia & Malnutrition 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH 4 days 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I attended the deceased from Jan 5, 1959 , to Sept 4, 1959 , that I last saw the deceased alive on Sept 3, 1959 , and that death occurred at 1100 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8801 Colesville Ave. DATE SIGNED 9/4/59 ACTUAL SIGNATURE Russell B. Arnold M.D. Silver Spring, Md. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D. Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll St NW				24a. REC'D BY REGISTRAR SEP 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

CERTIFICATE OF DEATH

NAME OF DECEASED Jacob Franklin Foster		AGE 20		SEX M	
DATE OF DEATH Feb 21st 1917		PLACE OF DEATH Towson Park		CITY Baltimore	
CAUSE OF DEATH Diphtheria		DISEASE Diphtheria		TREATMENT None	
SIGNATURE OF PHYSICIAN J. H. [illegible]		SIGNATURE OF DECEASED Jacob Franklin Foster		SIGNATURE OF WITNESSES J. H. [illegible] [illegible]	
DATE OF SIGNATURE Feb 21st 1917		PLACE OF SIGNATURE Towson Park		CITY Baltimore	

Given by [illegible] 21st Feb 1917
J. H. [illegible] 21st Feb 1917

10488

CERTIFICATE OF DEATH

Reg. Dist. No.

10460

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 426 E. Diamond Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorsey Middle C. Last Plummer		4. DATE OF DEATH Month Sept. Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
11. BIRTHPLACE (State or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marvin E. Plummer		14. MOTHER'S MAIDEN NAME Alice Clagett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 218-05-0220	
17. INFORMANT Mrs Rena Plummer, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm of Abdominal Aorta DUE TO 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO 15 YEARS (c) Generalized Arteriosclerosis 15 YEARS		INTERVAL BETWEEN ONSET AND DEATH KN HOURS 15 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF BLADDER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 1957, to September 9 , 1959, that I last saw the deceased alive on September 9 , 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Rosenberg		ADDRESS (Street, city or town, state) 26 N. Summit Ave Gaithersburg, Md.	
PHYSICIAN'S NAME (Type) Gaithersburg, Md.		DATE SIGNED Sept 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Moleworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE SEP 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10022

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH		CITY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	

AL AORTIC

12/21
12/21

9229X
2100A

21 2100A
21 2100A
21 2100A

0

10489

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE New Hampshire c. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wolfeboro 66X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS South Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ralph Middle Conrad Last POELMAN, JR.				4. DATE OF DEATH Month September Day 16 Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-54	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 5 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Conrad POELMAN				14. MOTHER'S MAIDEN NAME Novella SHARPE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital Heart Disease (Post operative state) Aortic Stenosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from August 26, 1959 to Sept. 16, 1959 , that I last saw the deceased alive on Sept. 16, 1959 , and that death occurred at 940 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Douglas R. Koth M.D. U. S. Naval Hospital 9-17-59 PHYSICIAN'S NAME (Type) Douglas R. KOTH, LCDR, MC, USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 9-17-59		22c. NAME OF CEMETERY OR CREMATORY Wolfeboro New Hampshire		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	

10488

CENTRAL OF TEXAS

Montgomery New Hampshire Carroll

Eschscholtz (Hans) El Paso Wolfboro

U. S. Naval Hospital South Main Street

Ralph Corbett PORTMAN, JR. September 19

Male Canonball 2-8-54

None Georgia U.S.A.

Ralph Corbett PORTMAN Woburn 2-MAR-54

None Hospital Records

Sept. 18 August 20 Sept. 18 50

U. S. Naval Hospital 2-11-54

Douglas R. Kuhn, CDR, MC, USN Bethesda, Maryland

Woburn New Hampshire

R. A. Freeman, Farmer, Home, Bethesda, Md.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

10462

10490

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVAL HOSP. NMMC		d. STREET ADDRESS 1030 N. Randolph	
3. NAME OF DECEASED (Type or print) First James Middle Richard Last PROBST		4. DATE OF DEATH Month Sept. Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Aug. 1959
9. AGE (In years last birthday) yrs. 22 Months 22 Days 22 Hours 22 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Donald Martin PROBST		14. MOTHER'S MAIDEN NAME Janet G.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs. Janet G. PROBST (Mother)	
17. INFORMANT Mrs. Janet G. PROBST (Mother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonitis, bilateral 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 763.0 (c), stating the underlying cause lost. (c) 763.0 DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 9-21-59	
EXAMINER'S NAME (Type) Frank J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-59	
22c. NAME OF CEMETERY OR CREMATORY Chestnut Level Presbyterian Church Lancaster, Penn.		22d. LOCATION (City, town, or county) (State) Bethesda Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.A. Pumphrey</i> R.A. Pumphrey		24a. REC'D BY REGISTRAR SEP 23 1959	
24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051201XV4

FOR STATE
HEALTH DEPT.

Examinee (Name)

US NAVY MEDICAL OFFICER

James

Richard

Robert

Male

James

Home

Daniel Martin Probst

Mr. James G. Probst (Name)

James Probst, Director

Out

Examinee (Name)
Examinee (Address)
Examinee (City)
Examinee (State)

Examinee (Name)
Examinee (Address)
Examinee (City)
Examinee (State)

Examinee (Name) ☐ Examinee (Address) ☐ Examinee (City) ☐ Examinee (State) ☐

Examinee (Name) ☐ Examinee (Address) ☐ Examinee (City) ☐ Examinee (State) ☐

James G. Probst

Examinee (Name) ☐ Examinee (Address) ☐ Examinee (City) ☐ Examinee (State) ☐

Examinee (Name) ☐ Examinee (Address) ☐ Examinee (City) ☐ Examinee (State) ☐

10491

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3730 Fordham Rd., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Neely RAINES		4. DATE OF DEATH Month Day Year September 16 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-08
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Giles RAINES		14. MOTHER'S MAIDEN NAME Bessie HOSKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1930to1959	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with diffuse metastases 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 18 mos (approx)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 5, 1959 to Sept. 16, 1959 , that I last saw the deceased alive on Sept. 15, 1959 and that death occurred at 430AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital DATE SIGNED 9-16-59 ACTUAL SIGNATURE G. I. Walker M.D. U.S. Naval Hospital PHYSICIAN'S NAME (Type) G. I. WALKER, CAPT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-18-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR SEP 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kinn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

Director of Columbia

Washington

42 days

Postcard (Hurry)

U.S. Naval Hospital

3130 Fortman Rd., N.W.

RAINES

Neely

George

Demotion

Male

U. S. Navy

Medical Officer

Barrie HODGINS

William Alfred RAINES

Hospital Records

Yes 1950-1951

Chronic bronchitis with emphysema
respiratory

15 mos (not)

X

1930

Sept 15

U.S. Naval Hospital 9-15-50

Postcard 14, Maryland

CAPT. MC. NEE

G. I. WALKER

Virginia

Arlington

National

9-15-50

Postcard

R.A. Thompson, General Home, Baltimore, Md.

10492

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 68 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 02-10-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1202 President Street			
3. NAME OF DECEASED (Type or print) First George Middle Perry Last RASMUSSEN				4. DATE OF DEATH Month September Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-23-99		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Rasmussen				14. MOTHER'S MAIDEN NAME Martha Griswold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWI & II		INFORMANT Address (W) Mrs. Mary A. Rasmussen, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma metastases 162.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1959 to Sept. 13, 1959 that I last saw the deceased alive on Sept. 12, 1959 , and that death occurred at 1:45 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 9-14-59							
ACTUAL SIGNATURE B. C. Johnson				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) B. C. Johnson, LCDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-59		22c. NAME OF CEMETERY OR CREMATORY Naval Academy		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Son, Annapolis, Md.				24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10492

CERTIFICATE OF DEATH

275

Maritime
Richards (Hunt) 28 June
U. S. Naval Hospital
George Perry
Male
Canadian
Marine
U.S. Navy
Tennessee
U.S.A.
Robert Randall
Marion Givens
Yes
Wife A-11
(W) Mrs. Mary A. Randall, name on 22

Sept. 13 1945
U. S. Naval Hospital
John M. Taylor & Son, Annapolis, Md.
Annapolis
Sept. 13 1945
U. S. Naval Hospital
Annapolis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810465

10494

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Regina		4. DATE OF DEATH Month September Day 17 Year 1959	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 5-22-59		9. AGE (In years lost birthday) 3 yrs. 10. IF UNDER 1 YEAR Months 3 Days 26 Hours 26 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) No. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo D. REYNOLDS		14. MOTHER'S MAIDEN NAME Willadean STURGILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Leo D. Reynolds, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 9, 1959 to Sept. 17, 1959 , that I last saw the deceased alive on Sept. 17, 1959 , and that death occurred at 2:26 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 9-17-59			
ACTUAL SIGNATURE Harry L. Walton		M.D. U. S. Naval Hospital	
PHYSICIAN'S NAME (Type) Harry L. WALTON, LT, MC, USN		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-18-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY R.A. Pumphrey Funeral Home, Bethesda, Md.		22d. LOCATION (City, town, or county) (State) Covington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 21 59		24b. REGISTRAR'S SIGNATURE Arthur A. Haines	

9VVVVVVVXXVV

RF 92-2

10/25/95 11:51 AM

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CERTIFICATE OF DEATH

Reg. Dist. No.

10495

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY BOY RIEDEL</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 2 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 2 1959</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN THOMAS RIEDEL</u>		14. MOTHER'S MAIDEN NAME <u>AUDREY MAR STILES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Twin 78 weeks</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spont. premature labor</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2</u> , 1959, to <u>9/2</u> , 1959, that I last saw the deceased alive on <u>9/2</u> , 1959, and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Albert S. Bright</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT S. BRIGHT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia M. Cantory</u>		24. REC'D BY REGISTRAR <u>Oct 5 1959</u>	
ADDRESS <u>Sept -</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

22 74275XUO

STATE OF TEXAS
COUNTY OF DALLAS

10488

OFFICE OF THE
CLERK OF THE DISTRICT COURT
DALLAS, TEXAS

10488

INVESTIGATION
OF THE
DEATH OF

10488

10496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>1 hr - 15 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>RIEDEL</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 2 1959</u>
9. AGE (In years lost birthday) <u>1</u> yrs. <u>15</u> Min.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN THOMAS RIEDEL</u>		14. MOTHER'S MAIDEN NAME <u>AUDREY MAE STILES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Twin 28 weeks</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Spont. Premature Labor</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/2</u> , 19 <u>59</u> , to <u>9/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Albert S. Bright</u> M.D.		PHYSICIAN'S NAME (Type) <u>ALBERT S. BRIGHT</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp. Bethesda, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia M. Custer, Supt.</u> ADDRESS <u>2174 274XUO</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10498
CERTIFICATE OF DEATH

[Faint, mostly illegible text and lines on a certificate form, likely containing fields for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH-18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10468

Reg. Dist. No.

10497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arthur Nursing Home - 9301 Wearn St</u>				d. STREET ADDRESS <u>4223 Round Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virvan C. K. Robey</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-18-896</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Robey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kelsner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Nursing Home Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Boeschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Boeschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-24-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10037

1-10-18

NAME OF DECEASED JAMES M. JONES		AGE 45		SEX Male		RACE White	
DATE OF DEATH Jan 10 1918		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		DURATION OF ILLNESS 10 days		PREVIOUS ILLNESS None	
SIGNS AND SYMPTOMS Fever, cough, expectoration		POST MORTEM EXAMINATION None		LABORATORY EXAMINATIONS None		HISTORICAL DATA None	
FAMILY HISTORY None		SOCIAL HISTORY None		OCCUPATION None		EDUCATION None	
RELIGION None		MARRIAGE HISTORY None		CHILDREN None		SIBLINGS None	
PARENTS None		GRANDPARENTS None		Aunts and Uncles None		Cousins None	
Siblings None		Children None		Grandchildren None		Nephews and Nieces None	
Signatures of witnesses None		Signature of Medical Examiner None		Signature of Coroner None		Signature of Registrar None	
Date of filing None		Place of filing None		County None		State None	

1

10037 JAMES M. JONES

1-10-18

Robert A. Jones, Secretary, Maryland

10037

Robert A. Jones, Secretary, Maryland

1-10-18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10498 CERTIFICATE OF DEATH

10469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Britannville</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Britannville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>S.</u> Last <u>Rayston</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Clarke Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Riddle Rayston</u>	
14. MOTHER'S MAIDEN NAME <u>Rhine V. Cooper</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>231-38-6162</u>		17. INFORMANT Address <u>Mrs. Louise Reed, Britannville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerosis-hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 sec.</u> <u>1 sec.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Frank L. Weaver Jr</u> M.D.				PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Calmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DeWitt Canalean, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 25 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10499 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Derwood</u>		LENGTH OF STAY (in this place) <u>10 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 1</u>				STREET ADDRESS (If rural give location) <u>R.F.D. # 1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Edward Lee Runion</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30 19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 13 1894</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Runion</u>				14. MOTHER'S MAIDEN NAME <u>Anne Bixler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hazel B. Runion Same As 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
526X IMMEDIATE CAUSE (A) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Brochiectasis</u>						<u>10 + yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 23, 19 59</u> , to <u>Sept 30, 19 59</u> , that I last saw the deceased alive on <u>Sept 29, 19 59</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above. <u>9/30/59</u>							
SIGNATURE <u>James W. Egan M.D.</u>		M.D. <u>7720 W. McLean Ave. Bethesda Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 3 59</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur H. Kinn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	

SMOULDS (M)

1
The following is a list of the names of the persons who have been
admitted to the hospital since the 1st of January, 1910, and
who have been discharged since the 1st of January, 1911.
The names are given in alphabetical order of the surnames.
The names of the persons who have been admitted to the hospital
since the 1st of January, 1910, and who have been discharged
since the 1st of January, 1911, are given in the following
list.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
10499
CERTIFICATE OF DEATH

Reg. Dist. No.

At what residence (name of deceased)

MARRIAGE

DATE OF DEATH

DECEASED

AGE

DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10500
CERTIFICATE OF DEATH

10471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 82 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Henrico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond d. STREET ADDRESS 411 Lakewood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Stephen Wilson Sawyer				4. DATE OF DEATH Month Day Year September 28, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1951	
9. AGE (In years last birthday) 7 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wilbur E. Sawyer				14. MOTHER'S MAIDEN NAME Jane Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Clinical Center Medical Record Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Meckel's diverticulum INTERVAL BETWEEN ONSET AND DEATH days 14 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1959 to September 28, 1959 , that I last saw the deceased alive on September 28, 1959 , and that death occurred at 2:30 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-28-59 ACTUAL SIGNATURE Jerry S. Trier M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Spotsylvania Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Lumphae				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '59	
				24b. REGISTRAR'S SIGNATURE Colleen S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

202110

NAME OF DECEASED

WILSON

AGE

32 years

SEX

Male

RACE

White

DATE OF BIRTH

January 20, 1907

PLACE OF BIRTH

Virginia

DATE OF DEATH

September 24, 1952

PLACE OF DEATH

Washington, D.C.

CAUSE OF DEATH

Myocardial infarction

IMMEDIATE CAUSE

Coronary artery disease

UNDERLYING CAUSE

Arteriosclerosis

DATE OF REPORT

October 1, 1952

REPORTED BY

Dr. J. H. Wilson

SIGNATURE

[Signature]

DATE

October 1, 1952

PLACE

Washington, D.C.

NAME

Dr. J. H. Wilson

ADDRESS

1111 Wisconsin Avenue, N.W., Washington, D.C.

CITY

Washington, D.C.

STATE

District of Columbia

COUNTRY

United States of America

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IMMEDIATE CAUSE

Coronary artery disease

UNDERLYING CAUSE

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DATE OF REPORT

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REPORTED BY

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SIGNATURE

[Signature]

DATE

October 1, 1952

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COUNTRY

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PLACE OF BIRTH

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DATE OF DEATH

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PLACE OF DEATH

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CAUSE OF DEATH

Myocardial infarction

IMMEDIATE CAUSE

Coronary artery disease

UNDERLYING CAUSE

Arteriosclerosis

DATE OF REPORT

October 1, 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10501

CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Fairfax ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 64 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83x-3	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 124 West Marshall Street	
3. NAME OF DECEASED (Type or print) First Middle Last Boyd Franklin Schaff		4. DATE OF DEATH Month Day Year September 8 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1909
9. AGE (In years lost birthday) yrs. 49		IF UNDER 1 YEAR Months Days Hours Min. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Noah L. Schaff		14. MOTHER'S MAIDEN NAME Margaret Faravee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock (Clinical) 1341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cryptococcosis (lungs & brain) DUE TO (c) Myeloid Metaplasia with pancytopenia			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 35 min. 3 mos. 21 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lt subdural, subarachnoid hemorrhage, jaundice			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6 , 19 59 , to September 8 , 19 59 , that I last saw the deceased alive on September 8 , 19 59 , and that death occurred at 5:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/8/59 ACTUAL SIGNATURE Vincent T. Andriole M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Vincent T. Andriole, M. D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Fairfax County Va	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Lee		ADDRESS Mass Arlington, Va.	
24a. REC'D BY REGISTRAR SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10502

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>De. Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Washington 116</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Congressional Mason Hall</i>				d. STREET ADDRESS <i>15104 Scarsdale Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Catherine H</i> Middle <i>Schroeter</i> Last <i>Schroeter</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>27</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-1868</i> 12-25-1867	9. AGE (In years last birthday) <i>90</i> yrs.	IF UNDER 1 YEAR Months <i>90</i> Days <i>0</i> Hours <i>0</i> Min.		IF UNDER 24 HRS. Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edw. Harber</i>				14. MOTHER'S MAIDEN NAME <i>Eliz. Hammerle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Anatomic Record</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Found dead in bed</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>Found dead in bed</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>9-27-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-3-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Marion, Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Santos Jones</i>				ADDRESS <i>1756 Park Ave. N.W. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 30 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur A. Hume</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, First, Middle Initial) <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>1910</u>	
5. PLACE OF BIRTH <u>NEW YORK</u>		6. OCCUPATION <u>Teacher</u>	
7. MARITAL STATUS <u>Married</u>		8. EDUCATION <u>High School Graduate</u>	
9. PRESENT RESIDENCE <u>123 Main St., Baltimore, Md.</u>		10. DATE OF DEATH <u>1955</u>	
11. TIME OF DEATH <u>10:15 AM</u>		12. PLACE OF DEATH <u>Home</u>	
13. CAUSE OF DEATH (Immediate) <u>Myocardial Infarction</u>		14. MANNER OF DEATH <u>Natural</u>	
15. UNDERLYING CAUSE OF DEATH (Final) <u>Coronary Atherosclerosis</u>		16. SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>	
17. SIGNATURE OF WITNESS <u>[Signature]</u>		18. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>[Signature]</u>	
19. SIGNATURE OF DECEASED'S NEXT OF KIN <u>[Signature]</u>		20. SIGNATURE OF DECEASED'S ATTORNEY <u>[Signature]</u>	
21. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL <u>[Signature]</u>		22. SIGNATURE OF DECEASED'S CHURCH CLERK <u>[Signature]</u>	
23. SIGNATURE OF DECEASED'S FUNERAL HOME <u>[Signature]</u>		24. SIGNATURE OF DECEASED'S BURIAL PLACE <u>[Signature]</u>	
25. SIGNATURE OF DECEASED'S CEMETERY <u>[Signature]</u>		26. SIGNATURE OF DECEASED'S INTERMENT <u>[Signature]</u>	
27. SIGNATURE OF DECEASED'S CREMATION <u>[Signature]</u>		28. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
29. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		30. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
31. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		32. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
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73. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		74. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
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79. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		80. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
81. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		82. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
83. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		84. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
85. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		86. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
87. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		88. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
89. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		90. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
91. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		92. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
93. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		94. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
95. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		96. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
97. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		98. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	
99. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>		100. SIGNATURE OF DECEASED'S REINTERMENT <u>[Signature]</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM + Hosp.</u>		d. STREET ADDRESS <u>17809 Garland Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Ellen</u> Last <u>Shaffer</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-'13</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John L. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Pedan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Liver Failure</u> DUE TO (c) <u>Carcinoma of Rectum c Metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 months</u> <u>1-2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5</u> , 19 <u>59</u> , to <u>Aug 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>59</u> , and that death occurred at <u>2:55</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred W Eastman</u> M.D.		ADDRESS (Street, city or town, state) <u>Takoma Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred W Eastman</u>		DATE SIGNED <u>9/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 9/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belleville, R.D. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW Wash DC</u>		24. REC'D BY REGISTRAR <u>SEP 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kiana</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10475

Reg. Dist. No.

10503

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Echo Heights</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5305 Tuscarawas Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lacotha</u> Middle <u>Shannon</u> Last <u>Shannon</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 30, 1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Erie, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert O. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Camp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband - Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus 30 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hr</u> <u>years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9-30-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 5 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS - 10 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine</u> <u>CARR</u> <u>SHAW</u>				4. DATE OF DEATH Month Day Year <u>9</u> <u>10</u> <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-7-1880</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA-</u>							
13. FATHER'S NAME <u>Wm. H. CARR</u>				14. MOTHER'S MAIDEN NAME <u>EMMA KLEINDINST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>212-14-5025</u>			
INFORMANT Address <u>Catherine S. Bridge-daughter - same 2d</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Congestive heart failure</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonian Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 46</u> , 19 <u>59</u> , to <u>10 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 Sept</u> , 19 <u>59</u> , and that death occurred at <u>1:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W S Murphy</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>615 W. Montg. Ave., Rockville, Md. 10 Sept 59</u>			
PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

10004

CHURCH (A.M.)

CHURCH (A.M.)

CHURCH (A.M.)

CHURCH (A.M.)

CHURCH (A.M.)

CHURCH (A.M.)

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CHURCH (A.M.)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>7 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Grace</i> First <i>Maud</i> Middle <i>Shoemaker</i> Last		4. DATE OF DEATH <i>Sept</i> Month <i>30</i> Day <i>1959</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-6-83</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>24</i> Hours <i></i> Min. <i></i>	IF UNDER 24 HRS. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>US</i>			
13. FATHER'S NAME <i>Marcellus Donn</i>		14. MOTHER'S MAIDEN NAME <i>Mary Gregg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Acute coronary occlusion and myocardial failure</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs - 10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-30-</i> , 19 <i>59</i> , to <i>9-30-</i> , 19 <i>59</i> , that I lost saw the deceased alive on <i>9-30-</i> , 19 <i>59</i> , and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>N. C. Shoemaker M.D.</i>		ADDRESS (Street, city or town, state) <i>8005 Woodbury Drive Silver Spring, Md</i>	
PHYSICIAN'S NAME (Type) <i>N. C. Shoemaker, M.D.</i>		DATE SIGNED <i>9/30/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/3/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DATE OCT 5/59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10479

Reg. Dist. No.

10505 Items 4, 15 Film 6248 9-16-59 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5619 La Fayette Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>1 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander John Singer</u>				4. DATE OF DEATH Month Day Year <u>Sept 8 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1923</u>	9. AGE (In years last birthday) <u>36 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>District of Columbia</u>	
13. FATHER'S NAME <u>B. Alexander Singer</u>				14. MOTHER'S MAIDEN NAME <u>Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>144-18-2344</u>		17. INFORMANT <u>Rosalie Singer above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Rockville, Maryland</u>		(State) <u>(State)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-8-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. Montg. Ave. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BY EXCITING—WILSON TO NEW YORK STATE CHAIRMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10480

10506

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 60 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1645 Trinidad Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle SINGLETON Last 4. DATE OF DEATH Month September Day 15 Year 19 59				5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-6-10 9. AGE (In years last birthday) 49 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker 11. BIRTHPLACE (State or foreign country) So. Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wade SINGLETON 14. MOTHER'S MAIDEN NAME Agnes MC BRIDE 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII 16. SOCIAL SECURITY NO. INFORMANT Address same as #2 (W) Mrs. Catherine L. Singleton,				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 17 , 19 59 , to Sept. 15 , 19 59 , that I last saw the deceased alive on Sept. 14 , 19 59 , and that death occurred at 3:25AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Douglas R. KOTH M.D. U. S. Naval Hospital 9-15-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Douglas R. KOTH, LCDR, MC, USN Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-18-59 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington Virginia				23. FUNERAL DIRECTOR'S SIGNATURE J. T. RHINES & CO., 3001 12th ST., NE, Wash DC 24a. REC'D BY REGISTRAR SEP 18 '59 24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

10150
215

OFFICE OF THE

10150

Director of

Director

Washington

60 days

Revised (Amended)

1005 Franklin Ave., S.W.

U. S. Naval Hospital

September 15

WASHINGTON

Health

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Health

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U.S.A.

So. Carolina

James Mc BRIDE

James Mc BRIDE

(W) Mrs. Catherine J. Stokerson

Will

Prothonotary records with notary

Sept. 15 1950

3:25AM

30

Sept. 15

9-15-50

U. S. Naval Hospital

Donna R. Lewis, Nurse, Washington, D.C.

Virginia

Washington

Washington National

9-15-50

James

J. F. HINES & CO., 3001 12th St., N.E., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10481

10507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY 75X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Center d. STREET ADDRESS R. D. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Priscilla Last Smith				4. DATE OF DEATH Month September Day 14 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1910 9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Putt				14. MOTHER'S MAIDEN NAME Clara Dickey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased Intracranial pressure DUE TO Secondary to Brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Respiratory Failure DUE TO (c) Death 9/14/59 INTERVAL BETWEEN ONSET AND DEATH 3 yrs ago							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 7, 19 59 , to September 14, 19 59 , that I lost saw the deceased alive on September 14, 19 59 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Joseph A. Adamkiewicz Jr., M.D.				PHYSICIAN'S NAME (Type) Joseph A. Adamkiewicz Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/59		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Indiana County, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR SEP 17 '59		24b. REGISTRAR'S SIGNATURE Carlton J. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10508

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film G248 9-21-59 et

10482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ga. Ave. near Burlington Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6103 Fair Oak Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle Lee Last Smoot				4. DATE OF DEATH Month Sept Day 14 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1920 April 13, 1920	
9. AGE (In years last birthday) 39 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Roy O. Smoot		14. MOTHER'S MAIDEN NAME Della Bly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 229-18-1858		17. INFORMANT Doris Smoot Address 6103 Fair Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion (c), stating the underlying cause last. DUE TO Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH ? sudden ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collapsed while driving truck which ran into tel. pole.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No evidence of injury					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 9/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-59		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1125

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. SIGNATURE OF EXAMINER	
9. SIGNATURE OF WITNESS		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF JURY		14. SIGNATURE OF JURY		15. SIGNATURE OF JURY		16. SIGNATURE OF JURY	
17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY	
29. SIGNATURE OF JURY		30. SIGNATURE OF JURY		31. SIGNATURE OF JURY		32. SIGNATURE OF JURY	
33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY	
45. SIGNATURE OF JURY		46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY		52. SIGNATURE OF JURY	
53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY		56. SIGNATURE OF JURY	
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69. SIGNATURE OF JURY		70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY		76. SIGNATURE OF JURY	
77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY	
89. SIGNATURE OF JURY		90. SIGNATURE OF JURY		91. SIGNATURE OF JURY		92. SIGNATURE OF JURY	
93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

10509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Belair	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Asbury Methodist Home for Aged, Inc.		d. STREET ADDRESS 12 x - 2	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Smothers Last Smothers		4. DATE OF DEATH Month SEPT Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mother not married		14. MOTHER'S MAIDEN NAME Rachel Smothers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive pulmonary embolism & pneumonia 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic arrhythmia fibrillation DUE TO (c) cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-29 , 19 56 , to Sept 9 , 19 59 , that I last saw the deceased alive on Sept. 2nd , 19 59 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah E. Glover		ADDRESS (Street, city or town, state) 10128 Cedar Lane Kensington, Md	
PHYSICIAN'S NAME (Type) Sarah E. Glover		DATE SIGNED 9-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/59	22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel Meth. Cem.	22d. LOCATION (City, town, or county) (State) Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Baeto. 17		ADDRESS	
24a. REC'D BY REGISTRAR SEP 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

2597

William

James Anthony ...
 James ...
 ...

1950
 2-28
 1950

1950
 2-28
 1950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL LEON SNOWDEN		4. DATE OF DEATH Month Day Year SEPTEMBER 13 19 59	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. Months Days Hours Min. 2	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES E. SNOWDEN		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME JACQUELINE JOHNSON	
16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity & Immaturity 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Partial atelectasis of lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPTEMBER 11 1959 , to SEPTEMBER 13 1959 , that I last saw the deceased alive on _____, 19____, and that death occurred at 10:25P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE G. F. Meadors M.D.			
PHYSICIAN'S NAME (Type) G. F. MEADORS, M. D. DAMASCUS, MARYLAND			
22a. BURIAL, CREMATION, REINTERMENT Buried	22b. DATE THEREOF 9/16/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion,	22d. LOCATION (City, town, or county) (State) Bookeville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Snowden		24a. REC'D BY REGISTRAR DATE SEP 29 '59	24b. REGISTRAR'S SIGNATURE Arthur R. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. MARITAL STATUS Single		12. EDUCATION Bachelor's Degree	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SURVIVAL OF DECEASED No	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF PHYSICIAN James Earl Ray	
19. SIGNATURE OF CORONER James Earl Ray		20. SIGNATURE OF JURY James Earl Ray		21. SIGNATURE OF JUDGE James Earl Ray	
22. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		23. SIGNATURE OF CLERK James Earl Ray		24. SIGNATURE OF RECORDS James Earl Ray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10485

CERTIFICATE OF DEATH

Reg. Dist. No.

10362

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San Hosp.</u>		d. STREET ADDRESS <u>811 Malcolm Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>(none)</u> Last <u>Solomon</u>		4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-97</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Isaac Simon</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son-Mr. Stanley Solomon</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 7</u> , 19 <u>59</u> , to <u>SEPT 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>SEPT 15</u> , 19 <u>59</u> , and that death occurred at <u>8:30 A</u> .M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>8723 Kinner Branch Rd Silver Spring, Md</u>	
DATE SIGNED <u>9/18/59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo Wash Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Washington</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10486

Reg. Dist. No.

10511

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>			
c. LENGTH OF STAY IN 1b <u>21 yrs</u>				d. STREET ADDRESS <u>Burdette Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Burdette Rd</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Casimir</u> Last <u>Somers</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-1887</u>	
9. AGE (in years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u>		IF UNDER 24 HRS. Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>4.3.40. retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>			
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Somoracki</u>				14. MOTHER'S MAIDEN NAME <u>Rosalia Hodnidska</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mae Somers (wif.)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Mobsawth</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF DEATH [Faint handwritten date]</p>	
<p>5. PLACE OF DEATH [Faint handwritten address]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. CAUSE OF DEATH [Faint handwritten cause]</p>		<p>8. MANNER OF DEATH [Faint handwritten manner]</p>	
<p>9. SIGNATURE OF EXAMINER [Faint signature]</p>		<p>10. SIGNATURE OF WITNESS [Faint signature]</p>	
<p>11. SIGNATURE OF JURY [Faint signature]</p>		<p>12. SIGNATURE OF CLERK [Faint signature]</p>	

1

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10512

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist. of Col.</u> b. COUNTY <u>—</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Kensington</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>5315 Conn. Ave. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>E.</u> Last <u>Spaulding</u>				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1882</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Albert Spaulding.</u>				14. MOTHER'S MAIDEN NAME <u>Nora Colburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-44-1531</u>		INFORMANT Address <u>Mary F. Spaulding, Same as 2. (Wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardio Respiratory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary heart disease</u> DUE TO (c) <u>Cardiac asthma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 18, 1959</u> to <u>Sept 2, 1959</u> that I last saw the deceased alive on <u>Sept 2, 1959</u> and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. A. Martinez</u>		M.D. <u>Waverly Bldg Beltsville</u>		ADDRESS (Street, city or town, state) <u>—</u>		DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>F. A. Martinez</u>		M.D. <u>MD.</u>					
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Medford, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co.</u>				ADDRESS <u>1400 Chapin St. NW Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Collins & House</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>1701 East West Highway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1701 East West Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Emily Stanley</u>		4. DATE OF DEATH Month Day Year <u>Sept 19 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1902</u>
9. AGE (In years last birthday) <u>57 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George P. Stryker</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Long</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Leslie W. Stanley - Slim</u> Address <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>hanging</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>974x</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found hanging by neck at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p.m. <u>9-19</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-19-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
RACE _____		OCCUPATION _____		RESIDENCE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		SIGNATURE OF EXAMINER _____	
MEDICAL HISTORY _____		PHYSICAL EXAMINATION _____		LABORATORY TESTS _____	
SOCIAL HISTORY _____		PSYCHOLOGICAL HISTORY _____		OTHER INFORMATION _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF JURY _____		SIGNATURE OF CORONER _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF FUNERAL HOME _____	

5-2

10514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle A. Last Steitz				4. DATE OF DEATH Month Sept. Day 30 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/84	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 4 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Andersen				14. MOTHER'S MAIDEN NAME Louis e Funk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of large bowel DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 5, 1959 to 9/30, 1959 that I last saw the deceased alive on 9-29, 1959 , and that death occurred at 11:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. T. Joyner M.D.				ADDRESS (Street, city or town, state) 8106 Maple Ridge Rd Bethesda, Md DATE SIGNED 9/30/59			
PHYSICIAN'S NAME (Type) William T. Joyner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans-Bur.		22b. DATE THEREOF 10-3-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Queens County, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS				24a. REC'D BY REGISTRAR OCT 5 1959 DATE		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10314

John A. ...

John A. ...

John A. ...

John A. ...

John A. ...

John A. ...

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10515

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 55 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Falls Church c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83 X-3 d. STREET ADDRESS 1207 Offutt Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Fred STEPHENS			4. DATE OF DEATH Month Day Year September 24 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-34	9. AGE (In years lost birthday) yrs. 25	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service station		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) New Jersey			
12. CITIZEN OF WHAT COUNTRY? U.S.		13. ATTENDING PHYSICIAN William E. STEPHENS					
14. MOTHER'S MAIDEN NAME Catherine CONTE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					
16. SOCIAL SECURITY NO. 1953-1955		17. INFORMANT 535 32 5777 (Wife) Barbara J. Stephens Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 31 July , 19 59 , to 24 Sept , 19 59 , that I last saw the deceased alive on 24 September 19 59 , and that death occurred at 11:34 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 9-25-59							
ACTUAL SIGNATURE William P. Baker		M.D. U.S. Naval Hospital, Bethesda Md.					
PHYSICIAN'S NAME (Type) W.P. BAKER LT MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington Virginia		22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home 7557 Wisconsin Ave. Bethesda Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 30 1959

Arthur E. Kraus

10015

CERTIFICATE OF DEATH

Virginia

Montgomery

Between (Date) 55 days

John Church

U.S. Naval Hospital, Bethesda Md.

1217 011th Drive

George P. 40

STEWART

28 September 50

Male White

1-2-50

85

Service station Commercial

5 - 1st day

U.S.

William E. STEWART

Caroline DOWNS

Yes

10-1-1955

28 57 (Male) Between 3.84 p.m. and 4.12 p.m.

U.S. Naval Hospital, Bethesda Md.

1217 011th Drive

George P. 40

STEWART

28 September 50

Male White

Service station Commercial

5 - 1st day

U.S.

William E. STEWART

Caroline DOWNS

Yes

10-1-1955

28 57 (Male) Between 3.84 p.m. and 4.12 p.m.

10516

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL STEVENSON</u>		4. DATE OF DEATH <u>September 18 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17, 1959</u>
9. AGE (In years lost birthday) yrs. <u>16</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOT GIVEN</u>		14. MOTHER'S MAIDEN NAME <u>BETTY ANN STEVENSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity & atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>59</u> to <u>9-18</u> , 19 <u>59</u> that I last saw the deceased alive on <u>9-18-</u> , 19 <u>59</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville, Md</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. TROENDLE</u>		DATE SIGNED <u>809 Viers Mill Rd. Rockville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 Old Georgetown Rd. Bethesda</u>		24a. REC'D BY REGISTRAR <u>ACT 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1074217XU1

1001

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

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10517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DETHESDA</u>				c. LENGTH OF STAY IN 1b <u>28 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>STEWART</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>	IF UNDER 24 HRS. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>STEWART</u>			
14. MOTHER'S MAIDEN NAME <u>FRANCIS JONES</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				INFORMANT (SISTER) Address <u>Rockville, Md. 62 W. MOORE AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerotic HD</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several yrs</u> <u>yes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the prostate metastases</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> to <u>9-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 13</u> , 19 <u>59</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>			
ACTUAL SIGNATURE <u>L. B. Bonditch, M.D.</u>				DATE SIGNED <u>9/14/59</u>			
PHYSICIAN'S NAME (Type) <u>L. B. Bonditch, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Smarden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

1951

100

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10368
CERTIFICATE OF DEATH

10493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>17</u> <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp</u>		d. STREET ADDRESS <u>17224 MINTER PLACE</u>	
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Thomas</u> Last <u>Stiles</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1904</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stiles</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, Jan 1942-1945</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS. Ruth Stiles</u>		Address <u>Takoma Park 7224 Minter Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, SUBARACHNOID, BASILAR, MASSIVE - SUDDEN</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u> </u> , 19 <u>50</u> , to <u>9/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>59</u> , and that death occurred at <u>3:50</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin H Harding</u>		ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash DC</u> DATE SIGNED <u>9/17/59</u>	
PHYSICIAN'S NAME (Type) <u>Edwin H Harding</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 22, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Haller</u>		ADDRESS <u>254 Carroll St NE</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>SEP 21 '59</u>			

CERTIFICATE OF DEATH

1935

RECEIVED
DIVISION OF
BIOLOGY
JAN 11 1936
PAC 001 134

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is oriented horizontally but contains vertical text on the left side.



10518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Seneca			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 71 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Christine Middle Mabell Last Swafford				4. DATE OF DEATH Month September Day 27 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1929		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker				10b. KIND OF BUSINESS OR INDUSTRY Textile Industry		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME George Collins				14. MOTHER'S MAIDEN NAME Minnie Sloan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) Unascertainable				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, Primary, Left Lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 18 , 19 59 , to September 27 , 19 59 , that I last saw the deceased alive on September 27 , 19 59 , and that death occurred at 2:00p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE V. T. Andriole M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-28-59			
PHYSICIAN'S NAME (Type) Vincent T. Andriole, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		9/30/59		O'Conner Mem. Park		Seneca, S. Car.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 1400 Chapin St. NW Wash, DC				24a. REC'D BY REGISTRAR DCT 1 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. *Chlorophyll*

of 1990.

and the following conditions:

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

10519

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE So. Carolina b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. STREET ADDRESS 777 Laurel Bay Blvd.			
3. NAME OF DECEASED (Type or print) First Donald Middle Raymond Last TERRELL				4. DATE OF DEATH Month September Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-54	
9. AGE (In years lost birthday) 5 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.		11. BIRTHPLACE (State or foreign country) No. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - -			
13. FATHER'S NAME Walter L. TERRELL				14. MOTHER'S MAIDEN NAME Monica PATTERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (F) Walter L. Terrell, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7540 IMMEDIATE CAUSE (a) Post-operative cardiectomy DUE TO Congenital Heart Disease (Tetralogy of Fallot) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Birth (c)				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 24, 1959 to September 3, 1959 , that I last saw the deceased alive on Sept. 3, 1959 , and that death occurred at 1015A AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. A. Broaddus, Jr.				ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 9-3-59			
PHYSICIAN'S NAME (Type) C. A. BROADDUS, Jr., CDR, MC, Bethesda, Maryland				M.D. USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-4-59				22c. NAME OF CEMETERY OR CREMATORY Indianapolis Indiana			
22b. DATE THEREOF 9-4-59				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Funeral Home, Bethesda, Md.			
24a. REC'D BY REGISTRAR SEP 8 '59				24b. REGISTRAR'S SIGNATURE Carlton E. K...			

1

051

2

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0512

Mr. J. J. Patterson

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Mr. J. J. Patterson

Mr. J. J. Patterson

Mr. J. J. Patterson

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

10520

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Pinellas			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearwater 48X-3			
c. LENGTH OF STAY IN 1b 6 days				d. STREET ADDRESS 608 Mariva Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Louis Middle Francis Last THIBAUT		4. DATE OF DEATH		Month September Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-85	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson J. THIBAUT				14. MOTHER'S MAIDEN NAME Mary DEMPSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & II		INFORMANT Address (W)Mrs. Hazel P. Thibault, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bronchogenic, with metastases 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 10, 1959 to Sept. 16, 1959 , that I last saw the deceased alive on Sept. 16, 1959 , and that death occurred at 640P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis J. Linehan Jr. M.D.				ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 9-17-59	
PHYSICIAN'S NAME (Type) F. J. LINEHAN, JR., LCDR, MC, USN Bethesda, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR SEP 21 '59		24b. REGISTRAR'S SIGNATURE John E. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10520

Deborah (Hurl)

U. S. Naval Hospital

Male

U. S. Navy

Nelson J. Thibault

Yes

6 days

608 Marine Ave.

THIBAUT

6-23-50

Connecticut

Mary DENNEY

(N) Mrs. Hazel E. Thibault, same as

Sept. 10

Sept. 10

U. S. Naval Hospital

U. S. Naval Hospital

Atkinson

Atkinson

CERTIFICATE OF DEATH

Reg. Dist. No.

10521

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9228 WOODLAND DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle M. Last THOMAS, JR.		4. DATE OF DEATH Month SEPT. Day 6 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/26
9. AGE (In years lost birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	11. IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY FOOD BROKERAGE FIRM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE M. THOMAS, SR.		14. MOTHER'S MAIDEN NAME LILLIAN SPENCER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) YES (If yes, give year or dates of service) WW # 2		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Address Mrs. Rita M. Thomas, 9228 Woodland Drive Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LARYNGEAL OBSTRUCTION DUE TO 474X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LARYNGITIS DUE TO (c) VIRUS INFECTION INTERVAL BETWEEN ONSET AND DEATH SUDDEN 3 DAYS 1 WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/31 , 19 59 , to 9/5 , 19 59 , that I last saw the deceased alive on 9/5 , 19 59 , and that death occurred at 4 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,011 Ga. Ave., Silver Spring, Md. DATE SIGNED 9/6/59			
ACTUAL SIGNATURE Henry W. Stout MD		M.D. 10,011 Ga. Ave., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) HENRY W. STOUT MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/9/59	22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATH. CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Liska		24a. REC'D BY REGISTRAR DATE SEP 9 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

DOCTOR NOTIFIED - RELEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

10522

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 53 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3 d. STREET ADDRESS 6581 N. 29th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Axel Kolbjorn THOMPSON				4. DATE OF DEATH Month Day Year September 2 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-72	
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S.A.		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andres Thompson				14. MOTHER'S MAIDEN NAME Dorthea (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) SA 4200		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Respiratory Failure DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic heart disease and debilitation DUE TO Arteriosclerotic heart disease and debilitation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11 , 19 59 , to Sept. 2 , 19 59 that I last saw the deceased alive on Sept. 2 , 19 59 and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 9-3-59							
ACTUAL SIGNATURE William P. Baker				M.D. U. S. Naval Hospital			
PHYSICIAN'S NAME (Type) W. P. BAKER, LT, MC, USN				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass. Ave., NW				24a. REC'D BY REGISTRAR DATE SEP 8 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0532

CERTIFICATE OF DEATH

Montgomery, Virginia, Arlington, 11-2-42

1. Name (Printed) ...
2. Date of Birth ...
3. Place of Birth ...

4. Sex ...
5. Race ...
6. Occupation ...

7. Cause of Death ...
8. Date of Death ...
9. Place of Death ...

10. Signature of Physician ...
11. Signature of Registrar ...

12. Signature of Coroner ...
13. Signature of Medical Examiner ...

14. Signature of ...
15. Signature of ...

16. Signature of ...
17. Signature of ...

18. Signature of ...
19. Signature of ...

20. Signature of ...
21. Signature of ...

10376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Nevada</u> b. COUNTY <u>Montgomery</u> ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>65X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u>				d. STREET ADDRESS <u>South Virginia St.</u> <u>Rockville/Five Waverly (San)</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vivian Stanley Thorpe</u>				4. DATE OF DEATH Month Day Year <u>Sept. 24 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>85 ?</u> yrs.	9. AGE (In years last birthday) <u>85 ?</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Marjorie V. Frankland, Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 d.</u> <u>2 d</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-9-</u> , 19 <u>56</u> , to <u>9-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-23</u> , 19 <u>59</u> , and that death occurred at <u>8:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Fleet Luckett</u>				ADDRESS (Street, city or town, state) <u>5000 Reno Rd N.W.</u>		DATE SIGNED <u>9/25/59</u>	
PHYSICIAN'S NAME (Type) <u>W. Fleet Luckett</u>				<u>5000 Reno Rd. N.W., Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Chase and Son</u>				ADDRESS <u>5103 Wis., Ave., N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH 18372

PLACE OF DEATH HOME		MARRIAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DATE OF DEATH JAN 10 1900		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
NAME OF DECEASED JOHN J. JONES		NAME OF DECEASED JOHN J. JONES	
SEX MALE		SEX MALE	
AGE 45		AGE 45	
OCCUPATION LABORER		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH IRELAND		PLACE OF BIRTH IRELAND	
DATE OF BIRTH JAN 10 1855		DATE OF BIRTH JAN 10 1855	
NAME OF FATHER JAMES JONES		NAME OF FATHER JAMES JONES	
NAME OF MOTHER MARY JONES		NAME OF MOTHER MARY JONES	
SIGNATURE OF DECEASED (if living)		SIGNATURE OF DECEASED (if living)	
SIGNATURE OF WITNESS (if living)		SIGNATURE OF WITNESS (if living)	
SIGNATURE OF PHYSICIAN (if living)		SIGNATURE OF PHYSICIAN (if living)	
SIGNATURE OF CLERK (if living)		SIGNATURE OF CLERK (if living)	

I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health.
 J. J. JONES
 CLERK

10523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oiney		c. LENGTH OF STAY IN 1b 2 hrs. 25 min. X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Tibbs			4. DATE OF DEATH Month Day Year September 10 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-59		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hour 2 Min 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph L. Tibbs			14. MOTHER'S MAIDEN NAME Dorothy Grace Lambert		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of lungs 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity and Immaturity DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/10/1959</u> , to <u>9/10/1959</u> , that I last saw the deceased alive on <u>9/10/1959</u> , and that death occurred at <u>3:32pm</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. W. Bird, M. D. M.D. Sandy Spring, Maryland 9/10/59 PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/59		22c. NAME OF CEMETERY OR CREMATORY Germantown Baptist Ch	
22d. LOCATION (City, town, or county) Germantown		(State) md			
23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Fortin, Gaithersburg Md			24a. REC'D BY REGISTRAR DATE SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Kraus

2073336X01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

THE STATE OF MARYLAND

County of _____

Dec. 22, 1922

City of _____

Monmouth County General Hospital, Inc.

December 10, 1922

3-0-22

White

Female

Maryland

Monmouth

Dorothy Grace Barker

Joseph L. Barker

Medical Records

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Sanitary Section, Maryland

James J. N. Smith, M.D.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

Monmouth County General Hospital, Inc.

CERTIFICATE OF DEATH

Reg. Dist. No.

10501

10524

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 516 STONINGTON ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle MARIE Last TROUTNER		4. DATE OF DEATH Month SEPT. Day 27 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/86
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS BRYAN		14. MOTHER'S MAIDEN NAME JOHANNA REITCHE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Eugene C. Spangler, 516 Stonington Rd. Silver Spring, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition DUE TO 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas DUE TO 2 yrs (c) 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 59 , to Sept 27 , 19 59 , that I last saw the deceased alive on Sept 18 , 19 59 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald Nelson		ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md.	
PHYSICIAN'S NAME (Type) DONALD NELSON		DATE SIGNED 44-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/59	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem. Park Cemetery,		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR SEP 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10501

CERTIFICATE OF DEATH

10501

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10502

10525

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. STREET ADDRESS 1315 Pennsylvania S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Henry Last TURK				4. DATE OF DEATH Month September Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-86	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (U.S. Navy) Did not work after retired		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Allen TURK			
14. MOTHER'S MAIDEN NAME Ada MATHEWS				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. unknown				INFORMANT (Wife) Cora Turk Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Squamous Cell Carcinoma of Esophagus DUE TO (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				20g. (County) D.C.		20h. (State) D.C.	
21. I certify that I attended the deceased from 26 August , 19 59 , to 24 Sept. , 19 59 , that I last saw the deceased alive on 24 September , 19 59 , and that death occurred at 6:32 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 24 Sept. 1959							
ACTUAL SIGNATURE Douglas R. Koth				M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) Douglas R. KOTH LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-28-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington				22e. (State) Virginia		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS				ADDRESS 517 11th St. S.E. Washington D.C.		24a. REC'D BY REGISTRAR SEP 30 59	
24b. REGISTRAR'S SIGNATURE Arthur E. Fennell				24c. (City or town) Washington D.C.			

10822

U.S. DEPT. OF COMMERCE

210

Montgomery

Beltheden (Rural)

29 days

Washington

U.S. Naval Hospital, Bethesda, Md.

TURK

Henry

William

Maria

Willie

U.S. Navy Hospital, Bethesda, Md.

AND MATHEWS

ALTON TURK

Yes W I UNKNOWN (Wife) GORE TURK Same as 15

29 days

29 days

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

VS A1S (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
10526 CERTIFICATE OF DEATH 10503									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 10 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Pa rk 18X-2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda 14, Md.					d. STREET ADDRESS 645 Chinlee Drive				
3. NAME OF DECEASED (Type or print) First Timothy Middle Kevin Last VAUGHN					4. DATE OF DEATH Month September Day 5 Year 1959				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1959		9. AGE (In years last birthday) yrs. 18 IF UNDER 1 YEAR Months 16 IF UNDER 24 HRS. Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George F. VAUGHAN					14. MOTHER'S MAIDEN NAME Lois CONTRELL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		INFORMANT Address (Father) George F. VAUGHAN (Same as #2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 082.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Etiology undetermined DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aseptic meningitis								INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4 September , 19 59 , to 5 September , 19 59 , that I last saw the deceased alive on 5 September , 19 59 , and that death occurred at 0:20A , from the causes and on the date stated above.									
ACTUAL SIGNATURE G.B. Avery					ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-5-59				
PHYSICIAN'S NAME (Type) G. B. AVERY, LT MC USN					U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-9-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington		22d. LOCATION (City, town, or county) (State) Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE PUMPHREY FUNERAL HOME, 8434 Georgia Ave., Silver Springs, Md.					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		

2051274XV5

SEP 9-59

Arthur L. Kneass

10708



CERTIFICATE OF DEATH

10708

State of Maryland
County of Baltimore
City of Baltimore
I, the undersigned, being a duly qualified physician, do hereby certify that on the 1st day of January, 1908, at the City of Baltimore, Maryland, died
John T. Smith, aged 45 years, born at the City of Baltimore, Maryland, on the 1st day of January, 1863.
The cause of death was
Dropsy of the heart, due to atheroma of the coronary arteries.
The death was
Natural.
Witness my hand and the seal of the State of Maryland, at the City of Baltimore, this 1st day of January, 1908.
J. T. Smith, M.D.
Physician

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

10369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>17 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>		d. STREET ADDRESS <i>311 Boyd Avenue</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Rosina</i> Middle <i>M</i> Last <i>Vincent</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph C. Duck</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Sauerswald</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Barbara M. Hanes</i>		Address <i>311 Boyd Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> <i>420.1</i> DUE TO (b) <i>Coronary Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Arteriosclerosis Generalized</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>10 MIN</i> <i>5 years</i> <i>10 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 19 <i>46</i> , to <i>20 Sept</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>19 Sept</i> , 19 <i>59</i> , and that death occurred at <i>10:30</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. B. Queen</i>		ADDRESS (Street, city or town, state) <i>7112 Willow Ave</i>	
PHYSICIAN'S NAME (Type) <i>M. B. QUEEN</i>		DATE SIGNED <i>20 Sept</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-23-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Sellers Sons Co</i>		ADDRESS <i>3605-14 St W</i>	
24a. REC'D BY REGISTRAR <i>SEP 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Julius G. King</i>	

10370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> 1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8118 - 14th Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANCIS Vollmer</u>		4. DATE OF DEATH Month Day Year <u>9 19 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-59</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 14 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Kakoma Park Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Vollmer</u>		14. MOTHER'S MAIDEN NAME <u>Annexa Xavese Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>762.0</u> DUE TO <u>Undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undetermined</u> (c) <u>Undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R Coleman MD</u> M.D.		ADDRESS (Street, city or town, state) <u>733 SLIGO AVE. SILVER SPRING, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN</u>		DATE SIGNED <u>9/20/59.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9/24/59</u>	<u>St. Marys</u>	<u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Co</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur B. Kline</u>			

2075192XV4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10527

CERTIFICATE OF DEATH

10506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6000 Springfield Drive		e. STREET ADDRESS 6000 Springfield Drive	
3. NAME OF DECEASED (Type or print) First ISABEL Middle GRAFF Last WALTEN		4. DATE OF DEATH Month Sept. Day 26, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1879
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Graff		14. MOTHER'S MAIDEN NAME Antonie Beneke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son		Address Dr. Maxmilian G. Walten	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) & Cardiac failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days 12 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/18 , 19 55 , to Sept 26 , 19 59 , that I last saw the deceased alive on Sept 26 , 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4630 Montgomery Ave., Bethesda, Maryland DATE SIGNED 9-26-59			
ACTUAL SIGNATURE A. J. Brennan		PHYSICIAN'S NAME (Type) ANDREW J. BRENNAN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 9-29-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Mausoleum		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL AIR OF TEXAS

1935

Montgomery

Maryland

Chattanooga

Cherry Chase

10 years

Cherry Chase

6000 Southside Drive

6000 Southside Drive

WALTER

WALTER

WALTER

Sept. 20

Oct. 12, 1935

Oct. 12, 1935

Anderson's

Anderson's

Dr. William E. Wilson

Dr. William E. Wilson

General Thompson

General Thompson

8/18 1935

8/18 1935

9-20-35

Reynolds, Maryland

Reynolds, Maryland

Will Henshaw

Will Henshaw

Will Henshaw

CERTIFICATE OF DEATH

Reg. Dist. No.

10371

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		<i>13x-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. & Hospital</i>				d. STREET ADDRESS <i>401 Montgomery St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Jane Weimer</i>		First Middle Last		4. DATE OF DEATH <i>Sept 23 1959</i>		Month Day Year	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-29-96</i>	
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Heart Counselor Children Center Lab</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Wood</i>				14. MOTHER'S MAIDEN NAME <i>Mamie Bigley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Donald W. Weimer</i> Address <i>337 Lemington</i> <i>Patents Chart Washington, D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior Coronary Occlusion with myocardial infarction</i> <i>420.0</i> DUE TO <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>17 years</i> DUE TO (c) <i>3 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus & Anuria</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 19 <i>59</i> , to <i>Sept. 23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept 23</i> , 19 <i>59</i> , and that death occurred at <i>11:50</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Russell B. Arnold</i>				DATE SIGNED <i>9/23/59</i>			
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold M.D.</i>				<i>Silver Spring, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/26/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hamerood Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Pittsburgh Penna.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. ...</i>				ADDRESS <i>...</i>		24a. REC'D BY REGISTRAR <i>SEP 23 59</i>	
						24b. REGISTRAR'S SIGNATURE <i>...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

CERTIFICATE OF DEATH

10371

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10508

Reg. Dist. No.

10528

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>APT. 104</u> <u>2711 GEORGIA AVE NW</u>			
3. NAME OF DECEASED (Type or print) First <u>SAVANNAH</u> Middle <u>WELBORN</u> Last <u>WELBORN</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>12/25 1900</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEKEEPING</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>SOLOMAN WELBORN</u>				14. MOTHER'S MAIDEN NAME <u>? GRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>DOAK WELBORN</u> Address <u>BALTIMORE, Md.</u> <u>647 W. FRANKLIN ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-18-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-21-1959</u>		22b. DATE THEREOF <u>Lincoln Mem</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suitland Rd</u>			
22d. LOCATION (City, town, or county) <u>BAD</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		ADDRESS <u>467 N St NW</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Trana</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10588

2-1-1918

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		COLOR <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal	
TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF DECEASED _____	
DATE OF EXAMINATION _____		DATE OF DEATH _____	

1

10588

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10509

Reg. Dist. No.

10529

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington 1, 83x-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1809 Queens Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sydney H. Wentworth</u>				4. DATE OF DEATH <u>9 17 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Wentworth</u>				14. MOTHER'S MAIDEN NAME <u>P. Harvey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>092-09-425</u>		17. INFORMANT <u>Bun Wentworth - Wife - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1/2 hr.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>McLain, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE Everly Funeral Home By <u>Manager</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
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64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	



10000

10530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ned Middle (none) Last Westover				4. DATE OF DEATH Month September Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1896	
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic & Electrician				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Edwin Westover				14. MOTHER'S MAIDEN NAME Ruth Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 208-07-0097			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative cardiac arrest 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acquired calcific aortic stenosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 minutes 20 years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 6, 1959 to September 15, 1959 that I last saw the deceased alive on September 15, 1959 , and that death occurred 11:05 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9-15-59 ACTUAL SIGNATURE E. Kent Carney, M.D. PHYSICIAN'S NAME (Type) E. Kent Carney, M.D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 9-19-59							
22c. NAME OF CEMETERY OR CREMATORY FOREST-LAWN Cem.							
22d. LOCATION (City, town, or county) (State) JOHNSTOWN - PA.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md. ADDRESS _____							
24a. REC'D BY REGISTRAR SEP 17 '59 DATE							
24b. REGISTRAR'S SIGNATURE Carlton S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10530

CENTRAL OFFICE OF HEALTH

RECEIVED

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The Clinical Center, Bethesda, Md., 14.

Box 8,

Red

(Name)

Westover

Yale

April 23, 1952

63

Spokane & Identification

Division

Investigation

One, John Westover

John Westover

Box 1

203-17-0007

The Clinical Center, Bethesda, Md., Maryland

Investigative division

Identified relative and/or associates

50 years

September 1, 1952

50

September 6, 1952

11:55 A

The Clinical Center

National Institute of Health

Bethesda, Md., Maryland

10531

CERTIFICATE OF DEATH

10511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>OakCrest Trailer Court</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OakCrest Germantown Md.</u>		c. LENGTH OF STAY IN 1b <u>12 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>KATHERINE</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Darlington Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Katherine Beathley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Roy P. Williams</u>		Address <u>Germantown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, Severe</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6 July</u> , 19 <u>59</u> , to <u>14 Sept.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>14 Sept.</u> , 19 <u>59</u> , and that death occurred at <u>5:5 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon M. Smith</u>		DATE SIGNED <u>14 Sept '59</u>	
PHYSICIAN'S NAME (Type) <u>Gordon M. Smith Md.</u>		ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailegg</u>		ADDRESS <u>Frederick, Maryland</u>	24a. REC'D BY REGISTRAR DATE <u>SEP 18 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998

Journal of Management Education 32(1)

1994

Figure 1 is a line graph showing the percentage of total energy expenditure (TEE) for different activities over a 24-hour period. The Y-axis is 'Percentage of TEE' (0-100) and the X-axis is 'Time of day' (0-24). The legend indicates: Sleeping (solid line), Sedentary (dashed line), Light (dotted line), Moderate (dash-dot line), and Vigorous (long-dashed line). Sleeping is highest at night (~30-40%). Sedentary is highest in the morning (~20-30%). Light activity is highest in the afternoon (~10-20%). Moderate and Vigorous activities are highest in the afternoon/evening (~10-20%).

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1994

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values obtained with

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* To be furnished only on 17-1 to

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10532
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle Edward Last Wilson		4. DATE OF DEATH Month 9 Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Johnson		14. MOTHER'S MAIDEN NAME Mary Grace Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary Grace Wilson		Address Woodstock, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Marasmus 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature infant (4½ lbs at birth)			INTERVAL BETWEEN ONSET AND DEATH 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-23- 19 59 , to 9-6- 19 59 , that I last saw the deceased alive on 9-5- 19 59 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 9-7-59			
ACTUAL SIGNATURE Charles S. Whitaker M.D.		DATE SIGNED 9-7-59	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9-7-59	22c. NAME OF CEMETERY OR CREMATORY St. Alphonsus	22d. LOCATION (City, town, or county) (State) Woodstock, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		ADDRESS Clarksville, Md.	24a. REC'D BY REGISTRAR DATE SEP 9 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

10533
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First <u>Hattie</u> Middle <u>Wilson</u> Last				4. DATE OF DEATH <u>Sept.</u> Month <u>1</u> Day <u>1959</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27-1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Taylorsville - N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Albert E. CHAPMAN</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pouey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hosp. Records</u>		Address <u>-</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senescent arteriosclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>		5 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-7-</u> , 19 <u>59</u> , to <u>9-1-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-31-</u> , 19 <u>59</u> , and that death occurred at <u>4-30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bond</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bond</u>				DATE SIGNED <u>Sept 9/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 9/4/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>LONGVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>TAYLORSVILLE, N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knox</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14516

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. BIRTH DATE 1888		6. BIRTH PLACE Maryland		7. MARRIAGE DATE 1915		8. MARRIAGE PLACE Maryland		9. DECEASED DATE 1953		10. DECEASED PLACE Baltimore	
11. OCCUPATION Carpenter		12. CAUSE OF DEATH Heart Disease		13. MANNER OF DEATH Natural		14. SIGNATURE OF DECEASED James H. Harris		15. SIGNATURE OF WITNESS John Doe		16. SIGNATURE OF DECEASED James H. Harris		17. SIGNATURE OF WITNESS John Doe		18. SIGNATURE OF DECEASED James H. Harris		19. SIGNATURE OF WITNESS John Doe		20. SIGNATURE OF DECEASED James H. Harris	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John Doe		23. SIGNATURE OF DECEASED James H. Harris		24. SIGNATURE OF WITNESS John Doe		25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS John Doe		27. SIGNATURE OF DECEASED James H. Harris		28. SIGNATURE OF WITNESS John Doe		29. SIGNATURE OF DECEASED James H. Harris		30. SIGNATURE OF WITNESS John Doe	
31. SIGNATURE OF DECEASED James H. Harris		32. SIGNATURE OF WITNESS John Doe		33. SIGNATURE OF DECEASED James H. Harris		34. SIGNATURE OF WITNESS John Doe		35. SIGNATURE OF DECEASED James H. Harris		36. SIGNATURE OF WITNESS John Doe		37. SIGNATURE OF DECEASED James H. Harris		38. SIGNATURE OF WITNESS John Doe		39. SIGNATURE OF DECEASED James H. Harris		40. SIGNATURE OF WITNESS John Doe	
41. SIGNATURE OF DECEASED James H. Harris		42. SIGNATURE OF WITNESS John Doe		43. SIGNATURE OF DECEASED James H. Harris		44. SIGNATURE OF WITNESS John Doe		45. SIGNATURE OF DECEASED James H. Harris		46. SIGNATURE OF WITNESS John Doe		47. SIGNATURE OF DECEASED James H. Harris		48. SIGNATURE OF WITNESS John Doe		49. SIGNATURE OF DECEASED James H. Harris		50. SIGNATURE OF WITNESS John Doe	
51. SIGNATURE OF DECEASED James H. Harris		52. SIGNATURE OF WITNESS John Doe		53. SIGNATURE OF DECEASED James H. Harris		54. SIGNATURE OF WITNESS John Doe		55. SIGNATURE OF DECEASED James H. Harris		56. SIGNATURE OF WITNESS John Doe		57. SIGNATURE OF DECEASED James H. Harris		58. SIGNATURE OF WITNESS John Doe		59. SIGNATURE OF DECEASED James H. Harris		60. SIGNATURE OF WITNESS John Doe	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESS John Doe		63. SIGNATURE OF DECEASED James H. Harris		64. SIGNATURE OF WITNESS John Doe		65. SIGNATURE OF DECEASED James H. Harris		66. SIGNATURE OF WITNESS John Doe		67. SIGNATURE OF DECEASED James H. Harris		68. SIGNATURE OF WITNESS John Doe		69. SIGNATURE OF DECEASED James H. Harris		70. SIGNATURE OF WITNESS John Doe	
71. SIGNATURE OF DECEASED James H. Harris		72. SIGNATURE OF WITNESS John Doe		73. SIGNATURE OF DECEASED James H. Harris		74. SIGNATURE OF WITNESS John Doe		75. SIGNATURE OF DECEASED James H. Harris		76. SIGNATURE OF WITNESS John Doe		77. SIGNATURE OF DECEASED James H. Harris		78. SIGNATURE OF WITNESS John Doe		79. SIGNATURE OF DECEASED James H. Harris		80. SIGNATURE OF WITNESS John Doe	
81. SIGNATURE OF DECEASED James H. Harris		82. SIGNATURE OF WITNESS John Doe		83. SIGNATURE OF DECEASED James H. Harris		84. SIGNATURE OF WITNESS John Doe		85. SIGNATURE OF DECEASED James H. Harris		86. SIGNATURE OF WITNESS John Doe		87. SIGNATURE OF DECEASED James H. Harris		88. SIGNATURE OF WITNESS John Doe		89. SIGNATURE OF DECEASED James H. Harris		90. SIGNATURE OF WITNESS John Doe	
91. SIGNATURE OF DECEASED James H. Harris		92. SIGNATURE OF WITNESS John Doe		93. SIGNATURE OF DECEASED James H. Harris		94. SIGNATURE OF WITNESS John Doe		95. SIGNATURE OF DECEASED James H. Harris		96. SIGNATURE OF WITNESS John Doe		97. SIGNATURE OF DECEASED James H. Harris		98. SIGNATURE OF WITNESS John Doe		99. SIGNATURE OF DECEASED James H. Harris		100. SIGNATURE OF WITNESS John Doe	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10514

10372 CERTIFICATE OF DEATH

Item 1 FilmG248 9-11-59 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MARYLAND</u>		STATE <u>District of Columbia</u> ✓		COUNTY	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>Takoma Park 3 mo.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 20 47x-3</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17300 Baltimore Avenue Cedar Haven Rest Home</u>				STREET ADDRESS (If rural give location) <u>1541 251th St. S.E.</u>			
3. NAME OF DECEASED (Type or Print) <u>Myrtle Margarette WOCKLEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 6, 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 30, 1897</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>	
13. FATHER'S NAME <u>Dennis Callahan</u>				14. MOTHER'S MAIDEN NAME <u>Malvina Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Nora Sandler, 1609 30th St. S.E., D.C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE <u>Arteriosclerosis, generalized</u>						<u>20 yrs</u>	
DUE TO ANTECEDENT CAUSE(S) <u>Cerebral Thrombosis & Paralysis</u>						<u>10 mo</u>	
DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <u>Cardiac Decompensation</u>						<u>1 WK.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 2, 1956</u> , to <u>Sept. 6, 1959</u> , that I last saw the deceased alive on <u>Sept. 5, 1959</u> , and that death occurred at <u>3:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walcott W. Gibson, M.D.</u>				ADDRESS (Street, city, town, state) <u>2412 Minnesota Ave. S.E., D.C.</u>		DATE SIGNED <u>9-6-59</u>	
23. BURIAL-CREATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-10-59</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Ft Myer, Va.</u>	
24. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Wash. D.C.</u>		ADDRESS	

10332 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME, RESIDENCE, INCOME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. AGENT OF DEATH

8. SEX

9. AGE

10. OCCUPATION

11. EDUCATION

12. RELIGION

13. MARITAL STATUS

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. DATE OF ENTRY INTO STATE

17. DATE OF ENTRY INTO COUNTY

18. DATE OF ENTRY INTO CITY

19. DATE OF ENTRY INTO WARD

20. DATE OF ENTRY INTO BLOCK

21. DATE OF ENTRY INTO HOUSE

22. DATE OF ENTRY INTO ROOM

23. DATE OF ENTRY INTO BED

24. DATE OF ENTRY INTO CHAIR

25. DATE OF ENTRY INTO COFFIN

26. DATE OF ENTRY INTO BURIAL

27. DATE OF ENTRY INTO INTERMENT

28. DATE OF ENTRY INTO CREMATION

29. DATE OF ENTRY INTO DISPOSITION

30. DATE OF ENTRY INTO RECORD

31. DATE OF ENTRY INTO INDEX

32. DATE OF ENTRY INTO FILE

33. DATE OF ENTRY INTO ARCHIVE

34. DATE OF ENTRY INTO LIBRARY

35. DATE OF ENTRY INTO MUSEUM

36. DATE OF ENTRY INTO GALLERY

37. DATE OF ENTRY INTO THEATRE

38. DATE OF ENTRY INTO CIRCUS

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86. DATE OF ENTRY INTO CIRCUS

UNCLASSIFIED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10534

CERTIFICATE OF DEATH

Item 8 Film G248 9-17-59 et

Reg. Dist. No.

10515

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		d. STREET ADDRESS <u>3728 Madison Pl N.A.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE (NMI) WOOD</u>		4. DATE OF DEATH Month Day Year <u>9 - 10 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1861 8-7-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Geographic</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Wood</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. BARRETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTHROSCLECTROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1959</u> to <u>SEPTEMBER 1959</u> that I last saw the deceased alive on <u>JULY 2, 1959</u> and that death occurred at <u>8:00 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5720 MacArthur Blvd. Washington D.C.</u> DATE SIGNED <u>Working in D.C.</u>			
ACTUAL SIGNATURE <u>Andrew E. Rudnai</u> M.D.		PHYSICIAN'S NAME (Type) <u>ANDREW E. RUDNAI</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12 Sept 59</u>		22b. DATE THEREOF <u>12 Sept 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>44 MacArthur NE DC</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlinda E. Hines</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William A. Baker</i>		2. DATE OF DEATH <i>May 11 1917</i>	
3. PLACE OF DEATH <i>Home</i>		4. COUNTY <i>Baltimore</i>	
5. CITY OR TOWN <i>Baltimore</i>		6. STREET <i>North Ave.</i>	
7. HOUSE NO. <i>1111</i>		8. AGE <i>65</i>	
9. SEX <i>Male</i>		10. RACE <i>White</i>	
11. OCCUPATION <i>None</i>		12. CAUSE OF DEATH <i>Heart Failure</i>	
13. DISEASE <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Wm. A. Baker</i>	
15. SIGNATURE OF WITNESSES <i>Wm. A. Baker</i>		16. SIGNATURE OF REGISTRAR <i>Wm. A. Baker</i>	
17. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		18. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
19. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		20. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
21. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		22. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
23. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		24. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
25. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		26. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
27. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		28. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
29. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		30. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
31. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		32. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
33. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		34. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
35. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		36. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
37. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		38. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
39. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		40. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
41. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		42. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
43. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		44. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
45. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		46. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
47. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		48. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
49. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		50. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
51. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		52. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
53. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		54. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
55. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		56. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
57. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		58. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
59. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		60. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
61. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		62. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
63. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		64. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
65. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		66. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
67. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		68. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
69. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		70. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
71. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		72. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
73. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		74. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
75. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		76. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
77. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		78. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
79. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		80. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
81. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		82. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
83. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		84. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
85. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		86. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
87. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		88. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
89. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		90. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
91. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		92. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
93. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		94. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	
95. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>		96. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>	
97. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>		98. SIGNATURE OF CLERK OF COURT <i>Wm. A. Baker</i>	
99. SIGNATURE OF JUDGE <i>Wm. A. Baker</i>		100. SIGNATURE OF SHERIFF <i>Wm. A. Baker</i>	

10373

CERTIFICATE OF DEATH

Reg. Dist. No. 10516

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 17 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) 910 Kennebec Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katie Middle May Last Wood		4. DATE OF DEATH Month September Day 20 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1866
9. AGE (In years lost birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram Barnes		14. MOTHER'S MAIDEN NAME Julia Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT George A. Wood - 174 Old Court House Road New Hyde Park, L.I.N.Y.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Heart Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease 10 years (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19 , 19 59 to Sept 20 , 19 59 , that I last saw the deceased alive on Sept 19 , 19 59 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1746 14th Street N.W. Washington D.C. DATE SIGNED 9/21/59			
ACTUAL SIGNATURE William T. Gill, Jr. M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/23/59	Glenwood Cemetery	Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DATE SEP 22 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hines

CERTIFICATE OF DEATH

Reg. Dist. No.

10535

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Washington, D.C. 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home.		d. STREET ADDRESS 31-15th Street N.E.	
3. NAME OF DECEASED (Type or print) First NORA Middle Wood Last Wood		4. DATE OF DEATH Month Sept. Day 14th. Year 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-1869
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hogue		14. MOTHER'S MAIDEN NAME Agnes Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 390-106-P	
17. INFORMANT Miss Lulu Hogue		Address 31-15th St. N.E. (sister)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Suppurative Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior chamber Pericarditis (c) Severely		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/13/59 to 9/14/59 , that I last saw the deceased alive on 9/13/59 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sydney Allen		DATE SIGNED 9/14/59	
PHYSICIAN'S NAME (Type) SAMUEL L. LLEN, M.D.		ADDRESS (Street, city or town, state) Washington, Maryland	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF 9-16-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons Co		ADDRESS 300-4th St. N.E.	
24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Colin S. H.	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPT. OF DEATH

10782

Washington, D.C.

21-15th Street N.W.

June 1, 1919

1919

White

Washington, Pa.

House

James Miller

William Rogers

300-10th St. N.W. (1919)

No. 10

Handwritten notes and signatures, including "James Miller" and "William Rogers".

Handwritten notes and signatures, including "James Miller" and "William Rogers".

Handwritten notes and signatures, including "James Miller" and "William Rogers".

Handwritten notes and signatures, including "James Miller" and "William Rogers".

Handwritten notes and signatures, including "James Miller" and "William Rogers".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10518

10536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Fort Pierce c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 104 Indian Hills Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vickie Middle Diane Last Young			4. DATE OF DEATH Month September Day 27 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1954		9. AGE (In years last birthday) 5 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John H. Young			14. MOTHER'S MAIDEN NAME Gladys Eller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 hrs 1 yr					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from August 23 , 19 59 , to September 27 , 19 59 , that I last saw the deceased alive on September 27 , 19 59 , and that death occurred at 8:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Arthur R. Rothman, M.D.		PHYSICIAN'S NAME (Type) Arthur R. Rothman, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
Burial		Oct. 1, 1959		-			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 1400 CHAPIN ST. NW Wash., D.C.		24a. REC'D BY REGISTRAR OCT 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur R. Thomas		25. (City or town) Atlanta, Ga.					

CERTIFICATE OF DEATH

1943

Name of Deceased		John J. Jones	
Sex		Male	
Age		35 years	
Date of Birth		May 1, 1908	
Place of Birth		Baltimore, Maryland	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Heart Disease	
Date of Death		September 11, 1943	
Place of Death		Baltimore, Maryland	
Physician		Dr. J. H. Smith	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Official Seal		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10537

CERTIFICATE OF DEATH

Reg. Dist. No.

10519

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 days 11 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
3. NAME OF DECEASED (Type or print) First Janis Middle Zvirbulis Last Zvirbulis		4. DATE OF DEATH Month September Day 16 Year 19 59	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1887	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Suburban Trust	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? Latvia ✓	
13. FATHER'S NAME Carl Zvirbulis		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-46-0058	
17. INFORMANT (Daughter) Vija Boniewicz		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 9, 1959 to Sept. 16, 1959 that I last saw the deceased alive on Sept. 15, 1959 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Maryland DATE SIGNED 9/16/59			
ACTUAL SIGNATURE G. Beoditch Hunter, Jr. M.D.			
PHYSICIAN'S NAME (Type) G. Beoditch Hunter, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

1871

CERTIFICATE OF DEATH

1871



Name of Deceased		Age		Sex		Color		Religion		Marital Status		Occupation		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Protestant		Single		Farmer		Heart Disease		10:00 AM		Farmhouse		Dr. J. Smith		T. J. Brown	
Date of Birth		Date of Death		Date of Burial		Place of Burial		Name of Minister		Name of Undertaker		Name of Coroner		Name of Jury		Name of Witnesses		Name of Witnesses		Name of Witnesses		Name of Witnesses	
Jan 1, 1826		April 10, 1871		April 12, 1871		Cemetery		Rev. J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe		J. Doe	

[Faint handwritten text and signatures are visible in the lower half of the form.]